



MEDICAL HISTORY FORM

Name: _____

Age: _____ Height: _____ Weight: _____

MEDICAL HISTORY: Please check the appropriate answer if you have or have ever had:

- | | | | |
|---------------------------|----------------------------------------------------------|----------------------------------|----------------------------------------------------------|
| Abnormal bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of breath/lung problem | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or black-out spells | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stomach ulcer/reflux | <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive scarring/keloids | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Autoimmune disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Irregular/rapid heartbeat | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| AIDS, ARC or HIV positive | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis/joint pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke or brain attack | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood clots | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Disorder of the eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Birth control use | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE: _____

- Do you smoke? Yes No How much? _____
- Consume alcohol? Yes No How much? _____
- Use recreational drugs? Yes No What kind? _____
- Use diet medications? Yes No Type? _____
- Use herbal products? Yes No List: _____
- Take vitamins? Yes No Kind? _____
- Take Aspirin? Yes No Dose? _____
- How many children do you have? _____

LIST ALL MEDICATIONS YOU TAKE (ALL prescribed and over the counter medications, including pain and homeopathic/herbal medications):

ALLERGIES: Medication: Yes No **Latex:** Yes No **Seasonal:** Yes No **Food:** Yes No
 Details: _____

LIST ALL SURGERIES (Please include ALL cosmetic, elective and/or emergency surgeries):

FAMILY HISTORY: (Please check any condition that is common in your blood relatives)

- Heart problems Diabetes Stroke DVT or blood clots Prolonged bleeding history
- Problems with anesthesia Anesthesia allergy High blood pressure Autoimmune disorder

 Patient Signature

 Date