Name: _____

Personal Health:

Do you now or have you ever had:

- Heart Disease (Heart attack, Irregular heartbeat, High blood pressure, etc.) Yes No
- Hyperlipidemia (High Cholesterol) Yes No
- Blood disorder (anemia, iron deficiency, Yes No
- Bleeding disorder (blood clots, DVT) Yes No
- Lung Disease (asthma, COPD, bronchitis) Yes No
- Kidney Disease (please specify) Yes No
- Liver Disease (Hepatitis, etc.) Yes No
- Digestive Problems (Nausea, Vomiting, Diarrhea, Colitis, Ulcer, etc.) Yes No
- Thyroid Disease Yes No
- Diabetes Yes No
- Lupus Yes No
- Arthritis (Osteo or Rheumatoid) Yes No
- Internal Cancer (If yes, what type?) Yes No
- Immunosuppression (HIV, Lymphoma, etc.) Yes No
- STDs (Genital warts, Syphilis, etc.) Yes No
- Neurological disease (Seizures, Headaches, Epilepsy, etc.) Yes No
- Parkinson's Disease Yes No
- Psychiatric Disorder (Depression, Bi-Polar, ADD, etc.) Yes No
- Hives Yes No
- Eczema Yes No
- Skin Cancers (If yes, specify Basal cell, Squamous cell, Melanoma) Yes No
- Any other skin problems:

  _____

  _____
- Any other medical problems:

  _____

  _____

Medications:
Please list any medications you are currently taking and their dosages:

_____

_____

_____

Allergies:

_____

_____

Review of Systems

(Have you experienced problems in any of these areas within the past months?)

- Head (incl. face) Yes _____
- Neck Yes _____
- Back (incl. spine) Yes _____
- Chest (incl. breast and axillae) Yes _____
- Genitalia, groin, buttocks Yes _____
- Abdomen Yes _____
- Extremity Yes _____
- Fever, chills, loss of appetite, etc. Yes _____
- Cardiovascular Yes _____
- Respiratory Yes _____
- Genitourinary Yes _____
- Gastrointestinal Yes _____
- Musculoskeletal Yes _____
- Skin Yes _____
- Neurological Yes _____
- Psychiatric Yes _____
- Endocrine Yes _____

Social History:

Do you or have you smoked tobacco?

- How long? _____
- How much? _____
- How long ago did you quit? _____

How much alcohol do you consume in a week?

None <1 2-7 >10

Do you use illegal drugs?

Yes _____ No

Surgery/Hospitalization	Date	Anesthesia Complications	Notes

Have you ever had:

- A blood transfusion? Yes _____
- A plasma transfusion? Yes _____
- Botox injections? Yes _____
- Fillers (Juvederm, Restylan, other)? Yes _____

Family History: (Father, Mother, Brother, Sister, Son, Daughter, Grandparent, Aunt, Uncle)

Please specify which cancer or disorder

	Afflicted Family Member	Notes
Adopted or Unknown		
Substance Abuse		
Psychiatric Disorder		
Hearing Loss		
Alzheimer's		
Dementia		
Parkinson's Disease		
Arthritis		
Lupus		
Thyroid Disease		
Diabetes		
Liver Disease		
Kidney Disease		
Drug Allergies		
Anesthesia Problems		
Abnormal Bleeding		
Abnormal Clotting		
Heart Attack		
Heart Disease		
High Blood Pressure		
Breast Cancer		
Brain Tumor		
Lung Cancer		
Other Internal Cancer		
Acne		
Eczema		
Psoriasis		
Collagen/Elastic Disorder		
Scleroderma		
Skin Cancer (Squamous cell, Basal cell, Melanoma)		
Skin disease		
Other		