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Patient Medical History Questionnaire

Patient's Name :_____ Date of Birth: _____Age:_____

Please describe the reason for your visit today:_____

Medications (Please Mark all that apply and list all medications including):

Anti-inflammatories (Please check any that you use):

Aspirin: ☐ Advil: ☐ Ibuprofen: ☐ Celebrex: ☐

Other:

Vitamins (Please check any that you use):

Multivitamin: ☐ Vit E: ☐ Vit C: ☐ Vit B: ☐

Other:

Herbal Medications:

Anticoagulants: Yes ○ No ○

What Steroids have you used ever?

Diabetes/ Sugar control Medication:

Medications: please list All prescription & nonprescription with the doses & frequency:

Do you have any DRUG ALLERGIES?: Yes ○ No ○

Please List & describe all drug allergies:

Have you ever used recreational drugs? Yes ○ No ○

What Kind? _____ **Quit date:** _____

Do You Smoke: Yes ○ No ○

How many cigarettes/day: _____ **How many years?** _____ **Quit Date:** _____

Do you drink alcohol? Yes ○ No ○

How many drinks/ Week _____**?**

Please Check the type of diet you eat:

Regular: ☐ Vegetarian: ☐ Diabetic: ☐

Other:

Please list ALL you Medical Problems & Past Surgeries with either the age or date of onset:

Please list the number of full term pregnancies: _____

Did you breast feed: Yes ○ No ○ **How long** _____

MEDICAL HISTORY :

Please mark any of the following problems which you have ever had:

Heart attack: ☐ Arrhythmia: ☐ Blood Clot: ☐

Keloid/Hypertrophic Scar Heart valve: ☐ Nerve issues: ☐ Hepatitis: ☐

Shortness of breath: ☐ Bruise easily: ☐ Tuberculosis: ☐ Liver disease: ☐

Thyroid disorder: ☐ Arthritis: ☐ Aids or HIV+: ☐ Rheumatic fever: ☐

Bone or joint disease: ☐ Cancer: ☐ Ulcer: ☐ Herpes / Zoster: ☐

Chemical peel / Retin A: ☐ Gout: ☐ Night sweats: ☐ Suicide attempt: ☐

Reynaud's disease: ☐ Skin cancer: ☐ Stroke: ☐ Diabetes: ☐

Blood transfusion: ☐ Connective tissue disease: ☐ Cold sore /sun blister: ☐

Unexplained weight loss: ☐

REVIEW OF SYSTEMS:

Please Describe any treatments you are undergoing or have had in the past :

Musculoskeletal:

Head, eyes, ears, nose or throat:

Heart or lungs:

Blood pressure, blood or bleeding disorders:

Stomach, liver or gastrointestinal tract:

Kidney urinary tract or Gynecological:

Skin,arteries or veins:

Psychiatric:

Anesthesia problems? Yes ○ No ○

List Results of all X-rays, EKG's, mammograms, or abnormal lab results done in past 12 months:

Please list all the medical problems in your blood relatives (including skin & breast cancer) Alive/dead/age in drop menu's, allow multiple grandmothers, grandfathers, daughter, son's, brothers and sisters. (no limitations):

Mother: problems:

Father: problems:

Siblings:problems:

Kids: problems:

Grandparents:

Please check any of the following you would like to learn more about:

Facelift: ☐ Breast Augmentation: ☐ Eyelid Surgery: ☐

Abdominoplasty: ☐ Glycolic acid skin treatments: ☐ Liposuction: ☐

Chemical peel / Retin-A therapy: ☐ Breast Cancer Reconstruction: ☐

Hand Surgery: ☐ Collagen/Fat injection: ☐ Breast Lift: ☐

Ear Piercing: ☐ Spider Veins: ☐ Breast reduction: ☐ SmartLipo: ☐

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