# MEDICAL HISTORY FORM

What do you wish to discuss today: _____

How long has this concerned you? _____

Do you have any special concerns/needs regarding your visit in order for us to take better care of you?

_____

**PAST MEDICAL HISTORY:** Have YOU ever had the following?

| | | |
|---|---|---|
| Epilepsy or Seizures ☐ Yes ☐ No | Glaucoma ☐ Yes ☐ No | Depression ☐ Yes ☐ No |
| Heart Disease ☐ Yes ☐ No | Diabetes ☐ Yes ☐ No | Kidney Disease ☐ Yes ☐ No |
| High Blood Pressure ☐ Yes ☐ No | Bleeding Tendency ☐ Yes ☐ No | Arthritis ☐ Yes ☐ No |
| Mitral Valve Prolapse ☐ Yes ☐ No | Blood Clots ☐ Yes ☐ No | Thyroid Disease ☐ Yes ☐ No |
| Cancer ☐ Yes ☐ No | Stroke ☐ Yes ☐ No | Tuberculosis ☐ Yes ☐ No |
| Anemia ☐ Yes ☐ No | Asthma ☐ Yes ☐ No | Cold Sores or Fever Blisters ☐ Yes ☐ No |
| Peptic Ulcer Disease ☐ Yes ☐ No | Hepatitis ☐ Yes ☐ No | Frequent Heartburn/Reflux ☐ Yes ☐ No |

Have you lost a significant amount of weight? ☐ Yes ☐ No How much: _____

Did you have surgery to lose the weight? ☐ Yes ☐ No **If yes,** what year: _____

Type of surgery:

Lap band Open RnY bypass Lap RnY bypass

Do you have a history of Sleep Apnea? ☐ Yes ☐ No Do you use a CPAP machine? ☐ Yes ☐ No

Have you ever received a transfusion? ☐ Yes ☐ No **If yes,** what year: _____

Are you positive for HIV? ☐ Yes ☐ No **If yes,** what year: _____

**SURGICAL History** *(Include Cosmetic)* Type and Date

1. _____
2. _____
3. _____

**Current MEDICATIONS** ☐ NONE

*(include non-prescriptions, vitamins and herbal supplement)*

1. _____
2. _____
3. _____

Have you ever had any problems with anesthesia? ☐Yes ☐No _____

**ALLERGIES** *(please include tape, latex, local anesthetics, seasonal irritants and their effects):* ☐NONE

## PAST SOCIAL HISTORY

Smoking *(type and amount per day)*: _____ Alcohol *(type and amt/wk):* _____

If former smoker, date quit: _____ Height: _____ Weight: _____

In the past year, have you used any illegal drugs or prescriptions for nonmedical reasons? ☐Yes ☐No *(list)*:

Have you traveled out of the country within the past 4 weeks? ☐Yes ☒No **If yes,** where?

**FAMILY HISTORY:** Has **ANY RELATIVE** ever had the following:

| | | |
|---|---|---|
| Breast cancer ☐N ☐Y<br>who: | Melanoma ☐N ☐Y<br>who: | Stroke ☒N ☐Y<br>who: |
| High Blood Pressure ☐N ☐Y<br>who: | Heart Disease ☐N ☐Y<br>who: | Diabetes ☐N ☒Y<br>who: |
| Kidney Disease ☐N ☐Y<br>who: | Depression ☐N ☐Y<br>who: | Blood clots *(legs or lungs)* ☐N ☐Y<br>who: |

**REVIEW OF SYSTEMS:** Do **YOU** have now or have you had within the last six months:

| **Constitutional:** | | | **Eyes:** | | | **Musculoskeletal:** | | |
|---|---|---|---|---|---|---|---|---|
| Fever | ☒ Yes | ☐ No | Dry eyes | ☐ Yes | ☐ No | Joint pain | ☐ Yes | ☐ No |
| Weight loss | ☐ Yes | ☐ No | Vision Changes | ☐ Yes | ☐ No | Muscle pain | ☐ Yes | ☐ No |
| Gastrointestinal | ☐ Yes | ☐ No | Respiratory | ☐ Yes | ☐ No | Psychiatric: | ☐ Yes | ☐ No |
| Abdominal Pain | ☐ Yes | ☐ No | Difficulty breathing | ☐ Yes | ☐ No | Depression | ☐ Yes | ☐ No |
| ENT | ☐ Yes | ☐ No | Genitourinary | ☐ Yes | ☐ No | Integument: | ☐ Yes | ☐ No |
| Allergies | ☐ Yes | ☐ No | Painful urination | ☐ Yes | ☐ No | Skin rashes | ☐ Yes | ☐ No |
| Chronic cough | ☐ Yes | ☐ No | Bloody urine | ☐ Yes | ☐ No | Keloids | ☐ Yes | ☐ No |
| Cardiovascular | ☐ Yes | ☐ No | Hematologic/Lymphatic | ☐ Yes | ☐ No | Neurologic | ☐ Yes | ☐ No |
| Chest pain | ☐ Yes | ☐ No | Swollen lymph nodes | ☐ Yes | ☐ No | Dizziness | ☐ Yes | ☐ No |
| Swollen feet/ankles | ☐ Yes | ☐ No | Easy bruising | ☐ Yes | ☐ No | Numbness | ☐ Yes | ☐ No |
| Rapid heart beat | ☐ Yes | ☐ No | Easy bleeding | ☐ Yes | ☐ No | Tingling | ☐ Yes | ☐ No |

## WOMEN ONLY:

Age of first period: _____

Date of last mammogram: _____

Breast lump or discharge? ☐Yes ☐No

Are you or could you be pregnant now? ☐Yes ☐No

Do you do regular self-breast examinations? ☐Yes ☐No

Number of pregnancies: _____ Number of children: _____

Did you breast feed? ☐Yes ☐No

## Please check items below to discuss today:

| FACIAL AGING OR SHAPE: | BREASTS: | BODY CONTOURING: |
|---|---|---|
| ☐ General facial aging | ☐ Smaller than desired breasts | ☐ Body contour irregularities or excess fat |
| ☐ Lines around nose/mouth | ☐ Sagging breasts | |
| ☐ Brow frown line | ☐ Large breasts | ☐ Loose belly skin |
| ☐ Fines lines and wrinkles | ☐ Large areolas or nipples | ☐ Loose arm skin |
| ☐ Eyes—sagging lids/dark circles | ☐ Inverted nipples | ☐ Loose thigh skin |
| ☐ Cheekbones | ☐ Breast shape | ☐ Drooping buttock |
| ☐ Jowls or Sagging neck skin | ☐ Different sized breasts | ☐ Change buttock shape |
| ☐ Chin | ☐ Breast reconstruction | ☐ History of massive weight loss |
| ☐ Nose | ☐ Male breast development | ☐ Vaginal Rejuvenation |
| | | ☐ Other: _____ |

## Please check items below to discuss today:

*(Select all that apply)*

| | | |
|---|---|---|
| ☐ BOTOX© | ☐ Sun protection | ☐ Skincare |
| ☐ BOTOX© to reduce underarm sweating | ☐ Organic Skincare | ☐ Medical Grade Skincare |
| ☐ Injectable fillers (Juvederm©, Voluma©) | ☐ FDA Approved Eyelash Growth (Latisse©) | |
| ☐ LUMECCA–Intense Light Therapy for brown & red spots | ☐ DIOLAZE - Laser Hair Removal | |
| ☐ FORMA - Noninvasive Tightening using RF energy | ☐ VASCULAZE - Spider Vein Treatment | |
| ☐ MORPHEUS–Minimally Invasive Resurfacing & Tightening using RF energy | | |

**I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.**

**X** _____ **Date:** _____

Signature of patient or parent/guardian of minor

**OFFICE USE ONLY: BP:** _____ **HR:** _____ **BMI:** _____ **BSA:** _____