Health History

Name_____Date of Birth:_____Todays Date:_____

Height:_____Weight_____ Are you currently under the care of a physician? Yes No

Family Physician name:_____

Past Medical History: Do you presently have or have you had any of the following

Y N Abnormal Bleeding
Y N AIDS/HIV
Y N Anemia
Y N Arthritis
Y N Asthma
Y N Autoimmune Conditions
Y N Blood Clots
Y N Bowel Problems
Constipation Bloating

Y N Cancer
Type_____
Y N Chemotherapy
Y N Cold Sores
Y N Depression
Y N Diabetes
Y N Dry Eyes
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Heart Conditions

Y N Hemophilia
Y N Hepatitis
Y N Herpes
Y N High Blood Pressure
Y N Kidney Problems
Y N Liver problems
Y N Low Blood Pressure
Y N Lung Conditions
Y N Mental Illness
Y N Neuromuscular conditions

Y N Polycystic Ovaries
Y N Radiation Treatment
Y N Seizures
Y N Sinus Problems
Y N Sleep Apnea
Y N Stroke
Y N Swollen Legs/Ankles
Y N Thyroid Problems
Y N Treatment by Psychiatrist or Psychologist

Any additional information not included above:_____

_____

Past Surgical History

List **ALL** surgeries (including cosmetic) you've had and their Dates:_____

_____

_____

_____

Do you bleed excessively from cuts or surgery? Yes No

Allergies: . None

List **ALL** allergies to medication **and** your reaction

_____

_____

_____

Are you allergic to Latex? Yes No

Are you allergic to Tape? Yes No

For Women

Are you Pregnant Yes No Lactating? Yes No

Number of Pregnancies_____Deliveries_____

Are you planning more children Yes No

Do you take Birth Control pills or hormones? Yes No

When was your last mammogram?_____

Medications: List **ALL** medication you are currently taking including non-prescription, vitamins, herbals and supplements.

_____

_____

_____

_____

Have you ever taken Accutane Yes No

Date last taken_____

Do you wear contact lenses? Yes No

Tobacco/Alcohol

Do you smoke or use tobacco or nicotine Yes No

Amount Daily_____Weekly_____

Have you ever smoked? Yes No

When did you stop smoking_____

Do you drink alcoholic beverages? Yes No

Have you ever been addicted to any drug or alcohol or used IV drugs? Yes No

Explain_____

_____

Family History

Family History of Breast Cancer? Yes No

Grandmother Mother Aunt Sister

Family History of Bleeding or clots? Yes No

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Patient Signature:_____Date:_____

Office Use Only_____

_____

_____

_____

_____