

MEDICAL HISTORY

Name: _____

Medication Allergy	None: []	Reaction

Current medication	Dose	How often?	Current medication	Dose	How often?

Prior surgery or hospitalizations: _____ Date: _____

Please list any complications or problems with anesthesia:

Height: _____ **Weight:** _____

- Yes No**
- [] [] Do you have frequent heartburn?
- [] [] Do you have acid reflux or indigestion when lying down?
- [] [] Do you have a hiatal hernia?
- [] [] Do you have a stoma or colostomy?
- [] [] Do you have hepatitis?
- [] [] Men: do you have prostate disease?
- [] [] Women: have you been pregnant in the past 3 months?
- [] [] Are you breast feeding?
- [] [] Do you have chronic pain?
Where: _____

- Yes No**
- [] [] Do you have areas of skin redness or breakdown? Where: _____
- [] [] Do you have arthritis?
- [] [] Do you have lupus?
- [] [] Do you have diabetes?
- [] [] Do you have thyroid disease?
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- [] [] Have you ever been diagnosed with cancer? What kind: _____
- [] [] Have you received chemotherapy?
- [] [] Have you received radiation?
Last treatment: _____

CONTINUED ON OTHER SIDE

Yes No

- Have you ever had a stroke?
- Do you have any paralysis?
- Do you have any memory loss?
- Do you have seizures?
- Do you have frequent headaches?
- Do you have any hearing loss?
- Do you have fainting spells?
- Do you have any speech difficulties?

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- Do you have glaucoma?
 - Do you have cataracts or lens implants?
 - Do you suffer from dry eyes?

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- Do you have high blood pressure?
 - Have you ever had a heart attack?
When? _____

- Do you get chest tightness?
- Do you have a heart murmur?
- Do you have mitral valve prolapse?
- Are you supposed to take antibiotics before a procedure or dental work?

- Do you have a pacemaker?
- Have you had rheumatic fever?
- Do you have an irregular heartbeat?
- Do you have any other heart disease?
What kind? _____

- Do you have trouble walking up a flight of stairs?
- Do you have trouble walking one mile?

Yes No

- Do you get short of breath?
- Do you asthma or wheezing?
Last ER visit: _____
- Have you ever had pneumonia?
When? _____
- Do you have bleeding problems?
- Do you have a blood disease?

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- Do you smoke?
Packs per day: _____
If you smoked in the past, when did you quit? _____

- Do you drink alcohol?
 Daily Weekends Less
- Do you use recreational drugs?
Type: _____
Last use: _____

Additional questions for children:

- Was your child born prematurely?
- Are your child's immunizations up to date?
- Was your child ever treated in an ICU?

Would you like us to pre-qualify you for cosmetic financing?

No

Yes! Please answer these additional questions:

1. Nearest relative's name _____
2. Nearest relative's phone _____
3. Monthly net income: _____
4. Own or rent: _____
3. Driver's license: _____ State _____ Exp. date _____

Patient/guardian signature: _____

Date: _____