<u>MEDICAL HISTORY</u>

Patient Name____ D.O.B.___________________________

Personal Medical History____

____

Past Surgeries ____

____

Medications you are taking at this time (including Supplements) ___________________________________

____

Aspirin or Blood Thinners (please list)____

Medications you are allergic to and your **<u>Reactions</u>** to them____

____

Height _____________ Weight ____________ Smoke? (list daily use)___________________

Have you **EVER** smoked?________________ If so, when did you quit?________________________

Recreational Drug Use___________________ Alcohol Use___________________________________

Family Medical History____

Family History of Clots (please circle): Yes No

Please circle all that apply to you:	Aids/HIV	Anesthesia Reactions	Asthma
Bad Scars/Keloids	Birth Control Pills	Bleeding Problems	Diabetes
Emotional Problems	Heart Problems	Hepatitis	High Blood Pressure
Hormone Replacement	Kidney Problems	Pregnant now	Pregnant last year
Psoriasis or Lupus	Reflux/GERD	Rheumatoid Arthritis	Sleep Apnea
Tape Reaction	Thyroid Problems		

History of Clots: Deep Venous Thrombosis or Pulmonary Embolus

PATIENT SIGNATURE____DATE____________________

REVIEWED BY____MD DATE____________________