MEDICAL HISTORY

Patient Name_____ Age _____ DOB _____

Personal Medical History _____

_____

Past Surgeries _____

_____

Current Medications, including supplements: _____

_____

_____

Medication allergies & reaction _____

_____

Height _____ Weight _____ Birth Control/Hormone Replacement: _____

Tobacco Use _____ Other nicotine use (vape) _____ If history of, when did you quit? _____

Recreational Drug Use _____ Alcohol Use (frequency) _____

Aspirin or Blood Thinners (please list) _____

Personal Medical History _____

_____

Pertinent Family Medical History _____

_____

Anesthesia Reactions: _____ Tape/Adhesive Reactions: _____

CIRCLE all that apply to you:

ADHD AIDS/HIV ASTHMA BLEEDING DISORDER CANCER CARDIAC ISSUES

DIABETES EMOTIONAL ISSUES HEPATITIS HIGH BLOOD PRESSURE

KIDNEY ISSUES LUPUS PSORIASIS REFLUX/GERD RHEUMATOID ARTHRITIS

SCARRING ISSUES SLEEP APNEA THYROID PROBLEMS

HISTORY OF BLOOD CLOTS: Y or N _____

PATIENT SIGNATURE_____DATE _____

REVIEWED BY _____MD DATE _____

EMAIL ADDRESS: _____

Updated 01/2019

MEDICAL HISTORY