Patient Name_____**Date**_____

Patient Height: _____ft. _____in. **Weight**: _____lbs. BMI (office use only): _____

To help give you the best possible care, please carefully complete all questions on this form. If unaware of an answer, leave it blank. (Circle "YES" or "NO" where indicated)

Do you have or have a history of the following?

1. Stomach Ulcer/Intestinal Disease/Colitis/Reflux---------- Yes No
2. Liver or gallbladder disease---------- Yes No
3. Lung problems (Asthma, Emphysema, Tuberculosis, etc.)---------- Yes No
4. Heart disease (Rheumatic fever, Pacemaker, etc.)---------- Yes No
5. Coronary Artery Disease, Atrial Fibrillation, Heart Failure---------- Yes No
6. High Blood Pressure---------- Yes No
7. High Cholesterol---------- Yes No
8. Stroke---------- Yes No
9. Diabetes---------- Yes No
10. Blood Clots or Pulmonary embolism---------- Yes No
11. Kidney, Urinary or Bladder problem ---------- Yes No
12. Venereal disease, type_____---------- Yes No
13. Blood disorder or lymph gland disorder---------- Yes No
14. Arthritis, joint problem or bone disease---------- Yes No
15. Eye disease (glaucoma, cataract, other) _____---------- Yes No
16. Thrombophlebitis (inflammation of the veins) ---------- Yes No
17. Cancer, type_____---------- Yes No
18. Neurological disorder---------- Yes No
19. Depression/ Anxiety disorder ---------- Yes No
20. Skin Problems (eczema, psoriasis, etc) ---------- Yes No
21. Thyroid problem---------- Yes No
22. Excessive bleeding when cut---------- Yes No
23. Difficulty with the healing of wounds---------- Yes No
24. Overgrown scars or keloids---------- Yes No
25. Allergy to local anesthetics---------- Yes No
26. X-ray treatments to your face to treat acne ---------- Yes No
27. Other Medical Condition_____

When was your last flu shot? date_____ never____ unable____

Have you had prior hospitalization and/or surgery? Yes No

If yes, please give the approximate dates and procedures performed:

_____

_____

Have you had a colonoscopy? Yes No If yes, when? _____

Do you have any allergies to medication, environment or food? Yes No

If yes, please list along with reaction: _____

Medications

Do you take any medications (prescription, over the counter, herbal remedies or vitamins)? Yes No

If yes, please list:_____

_____

_____

Do you take a blood thinner (incl. Aspirin)? Yes No If yes, please specify: _____

Social History

Are you a current smoker? ---------- Yes No If yes, how many_____pack(s) per day

Are you a former smoker? ----------Yes No If yes, when did you stop? _____

Do you do drugs? ---------- Yes No

Do you drink? ---------- Yes No If yes, how much_____

Family Medical History

	Age	Medical Illnesses/Health
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
Siblings	_____	_____
Other	_____	_____

For Women Only:

Date of last pap smear_____ Date of last mammogram_____

Have you had any children? ----------Yes No If yes, how many_____

Are you pregnant? -----Yes No Are you currently planning pregnancy? -------- Yes No

Please in form the doctor if at any time you plan to, or become pregnant during your treatment period.

What is the reason for your visit today? _____

_____

_____

Patient signature_____**Date**_____