

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 _____

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 inform 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** _____