



Health History

Date: _____ Patient Name: _____

Age: _____ Height: _____ Weight: _____ Family Physician: _____

Physician's Phone: (____) _____ Date of Last Physical Examination: _____

1.) Do you have or have you had: (check all that apply)

- Poor Circulation ----- Bleeding Tendency ----- Hepatitis
----- Blood Clots ----- Anemia (Low Blood) ----- Slow Healing
----- Stroke ----- Shortness of Breath ----- Stomach Ulcer
----- High Blood Pressure ----- Asthma ----- Kidney Disease
----- Heart Attack ----- Pneumonia ----- Epilepsy (seizures)
----- Heart Problems ----- Tuberculosis ----- Cancer
----- Rheumatic Fever ----- Diabetes (sugar) ----- Staph/MRSA Infection
----- Migraines ----- Hormone Imbalance ----- Arthritis
----- Goiter ----- Nervous Breakdown ----- Cold Sore/Herpes
----- Aids/HIV ----- Leukemia ----- High Fever

Yes No Do you smoke? How much? _____ How many Years? _____
Yes No Do you chew Nicorette or tobacco or use nicotine patches? If Yes, how often? _____
Yes No Do you consume alcohol? If Yes, how often/amount? _____
Yes No Do you usually drink over 6 cups of coffee a day?
Yes No Do you regularly exercise? Type of Activity _____ How often? _____
Yes No Do you use any Anti-Inflammatory/NSAIDs (Advil, Aleve, Aspirin, etc.)?
Yes No Do you wear contact lenses?
Yes No Do you have any allergies or skin sensitivities (example: Latex causes rashes)? If Yes, please list:

2.) List ALL Medications including prescriptions and over the counter vitamins & herbal supplements:
(Example: Adipex, Omega-3 Fish Oils, Levothyroxine, birth control, green tea, multi-vitamins, Aleve, ibuprofen, aspirin etc.)

3.) Please List all Operations you have had below:

Table with 4 columns: Procedure, Year, Reason, Surgeon

4.) **Have you ever developed a bad scar? Location and Injury:** _____

5.) **List any serious injuries or illnesses:** _____

6.) **Please list the specific areas of concern that you would like to discuss today:**

7.) **Do you know of any blood relatives who have or had: (circle and give relationship)**

Stroke	Yes	No	_____	Seizures	Yes	No	_____
Arthritis	Yes	No	_____	Asthma	Yes	No	_____
Tuberculosis	Yes	No	_____	Diabetes	Yes	No	_____
Kidney Disease	Yes	No	_____	Bleeding Tendency	Yes	No	_____
Leukemia	Yes	No	_____	Breast Cancer	Yes	No	_____
Goiter	Yes	No	_____	Skin Cancer	Yes	No	_____
Stomach Ulcers	Yes	No	_____	Other Cancer	Yes	No	_____
High Blood Pressure	Yes	No	_____	High Fever	Yes	No	_____
Staph/MRSA	Yes	No	_____	after Surgery			

8.) **Skin Care Treatments & Facial Surgery Consultations**

Yes No Have you ever seen a physician/technician for a skin care concern? If Yes, describe: _____

Yes No Are you currently seeing a physician/technician for a skin care concern? If Yes, describe: _____

Yes No Have you ever had a skin lesion removed? If Yes, location/type: _____

Yes No Have you had any laser therapies, chemical peels, or aggressive exfoliation in the last 3 weeks?

Yes No Do you use Botox or Dysport? If Yes, date of last treatment: _____

Yes No Do you use fillers? (Restylane, Juvederm, Radiesse, etc.) If Yes, date of last treatment: _____

Yes No Do you use a medical grade skin care program? If Yes, list: _____

Yes No Do you use or have you ever used Accutane? If Yes, Dosage: _____

Frequency: _____ Date Discontinued: _____

Yes No Are you currently taking antibiotics for any reason? If yes, what: _____

Yes No Do you use any topical medications? (Retin-A, Hydroquinone, Benzoyl Peroxide, Effudex, etc.)

If Yes, describe: _____

Yes No Do you have a healthy diet? Dietary Concerns: _____

Yes No Do you drink water? If Yes, How many glasses/day? _____

9.) **Women Only**

Yes No Are you still having menstrual periods? Date of last: _____

Yes No Are you pregnant or lactating? Number of Pregnancies: _____

Yes No Are you in a fertility program?

Yes No Have you ever had any lumps in your breasts? Location: _____

Yes No Have you ever had a mammogram? Date of Last: _____

Yes No Are you currently going through menopause?

Yes No Have you ever been diagnosed with Polycystic Ovarian Syndrome or Endometriosis?