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PATIENT NAME ____ DATE____________

MEDICAL HISTORY

☐ None

- ☐ Diabetes
- ☐ Stroke (year)
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Thyroid Disease
- ☐ Blood transfusions
- ☐ Glaucoma
- ☐ Chest Pain
- ☐ Asthma/ Chronic Lung Disease
- ☐ Arthritis
- ☐ Bell's Palsy
- ☐ Cancer
  - ☐ Hepatitis
- ☐ Macular Degeneration

Women under the age of 50:

Are you pregnant, nursing or is there any possibility you might be pregnant?

☐ Yes ☐ No

Date of Last Menstrual Period ____________________________

SKIN HISTORY

- ☐ Accutane treatment (Date Discontinued______________________________)
- ☐ Radiation treatment to the face
- ☐ Keloid or hypertrophic scarring
- ☐ History of herpes or cold sores on the face

SURGICAL HISTORY

- ☐ Hip/Knee Replacement
- ☐ Heart Surgery
- ☐ Abnormal Reactions to Anesthesia ________________________________

MEDICATIONS:

____

____

____

HERBAL MEDICATIONS/VITAMINS

____

____

____

Do you take any type of blood thinners such as coumadin, heparin or aspirin?

☐ yes ☐ no

Do you take any type of anti-inflammatory or pain medication for cramps or arthritis?

☐ yes ☐ no

ANESTHESIA HISTORY

Have you ever had an adverse reaction to any anesthetic agents? ☐ yes ☐ no

If yes please describe below

____

ALLERGIES TO MEDICATIONS ☐ No Known Allergies

☐ Yes ____________________

SOCIAL HISTORY ☐ Smoking____________________

☐ Alcohol____________________

CURRENT OCCUPATION:

____

FAMILY HISTORY

☐ Diabetes____________________

☐ Glaucoma____________________

☐ Heart Disease________________

☐ Anesthesia Complications_________

☐ Stroke____________________

☐ Aneurysms__________________

REVIEW OF SYSTEMS

Dear patient:

As per insurance regulations all patients must complete the following questionnaire. Please circle yes (Y) or no (N).

Have you experienced any of the following symptoms lately?

Constitutional

- Weight loss Y N
- Fever Y N
- Night Sweats Y N

Ear/Nose/ Throat

- Hearing Loss Y N
- Ringing in ears Y N
- Chronic sore throat Y N
- Bloody nose Y N

Cardiovascular

- Palpitations Y N
- Chest Pain Y N

Respiratory

- Chronic cough Y N
- Bloody sputum Y N
- Shortness of Breath Y N

Gastrointestinal

- Diarrhea Y N
- Constipation Y N
- Bloody stools Y N
- Incontinence Y N

Neurological

- Headaches Y N
- Numbness of arms/legs Y N
- Weakness of arms/legs Y N
- Dizziness Y N

Musculoskeletal

- Joint pain Y N
- Muscle pain Y N

Skin

- Rashes Y N
- Easy Bruising Y N

Urinary

- Frequent Urination Y N
- Bloody Urine Y N
- Pain/discharge with urine Y N

Allergic

- Swelling of fingers/toes Y N
- redness/scaling Y N

Hematologic

- Unexplained bleeding Y N
- Bleeding of gums Y N

Eyes

- Double Vision Y N
- Dry Eyes Y N
- Redness Y N
- Pain Y N