

Name: _____ Reason for this visit: _____

Are you interested in information on our medical skin care products: Y N

Areas of concern: Uneven skin tone A Acne A Lines/Wrinkles A

MEDICAL HISTORY In the last six months have you had:

Abdominal bleeding	Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Attack	Y <input type="checkbox"/> N <input type="checkbox"/>	Fainting spells	Y <input type="checkbox"/> N <input type="checkbox"/>
Coronary Surgery	Y <input type="checkbox"/> N <input type="checkbox"/>	Cancer	Y <input type="checkbox"/> N <input type="checkbox"/>	Snoring/Sleep Apnea	Y <input type="checkbox"/> N <input type="checkbox"/>
Kidney Disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Hypertension	Y <input type="checkbox"/> N <input type="checkbox"/>	Anemia	Y <input type="checkbox"/> N <input type="checkbox"/>
Abnormal Clotting	Y <input type="checkbox"/> N <input type="checkbox"/>	Keloid scars	Y <input type="checkbox"/> N <input type="checkbox"/>	Angina	Y <input type="checkbox"/> N <input type="checkbox"/>
Diabetes	Y <input type="checkbox"/> N <input type="checkbox"/>	Asthma	Y <input type="checkbox"/> N <input type="checkbox"/>	Hepatitis	Y <input type="checkbox"/> N <input type="checkbox"/>
Tuberculosis	Y <input type="checkbox"/> N <input type="checkbox"/>	Acid regurgitation	Y <input type="checkbox"/> N <input type="checkbox"/>		

Previous Surgery, year and type of procedure: _____

Indicate the types of anesthesia received in the past, list any complications/reactions you experienced:

A Local anesthesia: complications/reactions _____

A General anesthesia: complications/reactions _____

A Spinal/Epidural: complications/reactions _____

SOCIAL

Married Y N Occupation: _____

Responsible adult available to assist during surgery Y N Relationship: _____

Number of pregnancies: _____ Number of Children _____ Did you breast feed Y ANA

Last Mammogram date: _____ Results: _____

HABITS

Smoke Y N Amount: _____ Coffee/Tea/Cola Y N Amount _____

Alcohol Y N Amount: _____ Daily Exercise Y N Amount _____

FAMILY HISTORY have any blood relatives ever had the following problems:

Abnormal bleeding	Y <input type="checkbox"/> N <input type="checkbox"/>	Diabetes	Y <input type="checkbox"/> N <input type="checkbox"/>	Cancer	Y <input type="checkbox"/> N <input type="checkbox"/>
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Coronary Disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Tuberculosis	Y <input type="checkbox"/> N <input type="checkbox"/>	Hypertension	Y <input type="checkbox"/> N <input type="checkbox"/>
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Kidney Disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Anesthetic problems	Y <input type="checkbox"/> N <input type="checkbox"/>	Keloid scars	Y <input type="checkbox"/> N <input type="checkbox"/>
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Abnormal Clotting	Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Attack	Y <input type="checkbox"/> N <input type="checkbox"/>	Breast Cancer	Y <input type="checkbox"/> N <input type="checkbox"/>
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MEDICATIONS List dose or number of pills per day

Prescription Drugs

Non Prescription Drugs (vitamins/herbs)

Regular Aspirin Use: Y N

Dosage & Frequency:

Drug Allergy Y N

Latex Allergy Y N

Tape Allergy Y N

List Drugs and type of reaction:

Height: _____ Weight" _____ Weight change past 12 months? Y N How much? _____