Medical History

Name____ Date_____________________

Height____________________________Weight___________________If female, are you pregnant? ☐ Yes ☐ No

MEDICATIONS/DRUGS-Please list ALL medications you are now taking including over-the- counter medicines and herbals. List Dosage.

1. ____________________________ 5. ____________________________ 9. ____________________________
2. ____________________________ 6. ____________________________ 10. ____________________________
3. ____________________________ 7. ____________________________ 11. ____________________________
4. ____________________________ 8. ____________________________ 12. ____________________________

ALLERGIES- Please list all allergies and or sensitivities along with associated reaction.

1. ________________________________Rxn__________ 5. ______________________________Rxn__________
2. ________________________________Rxn__________ 6. ______________________________Rxn__________
3. ________________________________Rxn__________ 7. ______________________________Rxn__________

Previous Surgical Procedures   Year   Hospital or City   Surgeon   Anesthesia (Local or General)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Other Hospitalizations, illness or injuries (if different than above)

1. ____
2. ____

What is your approximate DAILY consumption of the following

Aspirin____________   Nicotine (Tobacco, Nicotine gum, etc.)__________   Alcohol__________

Past Medical History- Please check all that applies to you. I HAVE HAD OR HAVE:

- ☐ Asthma
- ☐ Shortness of breath/COPD/Wheezing
- ☐ Respiratory problems
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Chest Pain/Tightness
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Irregular Heart Beat
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Phlebitis
- ☐ Pulmonary embolism/blood clot
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Anemia
- ☐ Bleeds easily
- ☐ Blood transfusion
- ☐ Taking blood thinners
- ☐ Autoimmune /Rheumatoid disease
- ☐ Arthritis
- ☐ Transplant Anti Rejection Drugs
- ☐ Breast Cancer
- ☐ Cancer
- ☐ Bladder Problems
- ☐ Kidney Problems

- ☐ Hepatitis A,B, or C
- ☐ HIV Positive
- ☐ Ulcer disease/Stomach problems
- ☐ Epilepsy or Seizures
- ☐ Fainting
- ☐ Migraines
- ☐ Paralysis
- ☐ Accutane in the last 3 months
- ☐ Changing moles or skin lesions
- ☐ Acne
- ☐ Dark spots after pregnancy
- ☐ Displastic Nevus
- ☐ Herpes simplex or fever blisters
- ☐ Hirsutism
- ☐ Keloid or thick scars
- ☐ Melanoma
- ☐ Psoriasis or Vitiligo
- ☐ Skin Cancer
- ☐ Skin Disease
- ☐ Bad reaction to general anesthesia
- ☐ Required unusually large amounts of Local anesthesia
- ☐ Post Op Nausea
- ☐ Nausea, vomiting, diarrhea when taking antibiotics
- ☐ Yeast infection with antibiotics

- ☐ Psychiatric care or advised to see a Psychiatrist
- ☐ Significant emotional problems
- ☐ Recreational drug use
- ☐ IV drug use
- ☐ Allergic to adhesive tape

Family History

- ☐ Abnormal Bleeding
- ☐ Abnormal Clotting
- ☐ Anesthesia Problems
- ☐ Breast Cancer
- ☐ Hemophilia
- ☐ Malignant Hyperthermia
- ☐ Von Willebrand
- ☐ Bad reaction to anesthesia

Please explain all positive answers on the reverse side