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MEDICAL HISTORY **DATE:_____**

Name: _____ Nickname:_____

First Middle Last

Age:_____ Sex: Male/Femal Race:_____ Height:_____ Weight:_____

Reason for visit: _____

PAST MEDICAL HISTORY List any medical conditions for which you have been treated:

_____

_____

PAST SURGICAL HISTORY List any operations, including cosmetic, you have had:

_____

_____

_____

Do you NOW or have you EVER had: (please check yes or no)

yes	no		yes	no		yes	no		yes	no	
☐	☐	chronic headaches	☐	☐	sleep apnea	☐	☐	thyroid disease	☐	☐	bleeding disorder
☐	☐	seizures	☐	☐	heart disease	☐	☐	liver disease	☐	☐	blood clot
☐	☐	stroke	☐	☐	heart attack	☐	☐	hepatitis	☐	☐	fibromyalgia
☐	☐	numbness/tingling	☐	☐	heart murmur	☐	☐	kidney disease	☐	☐	arthritis
☐	☐	sinus problems	☐	☐	mitral valve prolapse	☐	☐	IBS/gastroenteritis	☐	☐	TMJ/lockjaw
☐	☐	anxiety	☐	☐	pacemaker	☐	☐	diabetes	☐	☐	dermatitis
☐	☐	depression	☐	☐	irregular heartbeats	☐	☐	hypoglycemia	☐	☐	skin diseases
☐	☐	asthma	☐	☐	high blood pressure	☐	☐	GERD/reflux/ulcers	☐	☐	metal implants
☐	☐	lung disease/COPD	☐	☐	high cholesterol	☐	☐	cancer	☐	☐	latex sensitivity
☐	☐	tuberculosis	☐	☐	breast disease	☐	☐	immune disorder	☐	☐	herpes/cold sores

Please list all **MEDICATIONS** and **dosage** recently or regularly taken (include herbal and vitamins):

_____

_____

Please list all **ALLERGIES AND REACTIONS** to any **medications**:_____

_____

Please list any **NON-MEDICATION ALLERGIES** (i.e. latex, seasonal):_____

_____

WOMEN'S HEALTH

Have you ever been pregnant: _____How many times:_____ How many deliveries:_____

How many children do you have: _____ Did you breastfeed:_____ When did you stop: _____

Date of most recent MAMMOGRAM:_____ Results:_____

Breast augmentation/reduction patients: Current bra size: _____ Desired bra size: _____

Date of prior Augmentation: _____ **Circle one**: SALINE or SILICONE / UNDER or OVER the muscle?

Where is incision? _____ How many cc's? _____ History of capsular contracture? Y/N

Liposuction / tummy tuck patients: Are you at your goal weight?_____ Interested in weight loss program?_____

SOCIAL HISTORY (Please answer all questions even if it is Not Applicable to you)

Have you ever regularly smoked cigarettes / tobacco? YES/NO If yes, how many packs per day? _____

How many years did you smoke? _____ When did you stop smoking? _____

Alcohol Use: None / Occasionally / Daily History of Drug use:_____

Exercise: None / Occasionally / Daily Diet Pills:_____

Occupation/normal activity level:_____

FAMILY HISTORY Please list any illnesses that run in your family:_____