



PATIENT HISTORY

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

GENERAL MEDICAL HEALTH							
Diabetic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Issues	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid-hypo	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid-hyper	<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of Keloids	<input type="checkbox"/> Yes <input type="checkbox"/> No
Migraines	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
History of Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis C	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Other _____							
PAST SURGICAL PROCEDURES							
Date	Type			Comments			
FACIAL PROCEDURES							
Date	Type			Comments			
MEDICATIONS							
Name of Medication				Amount		Times Per Day	
ALLERGIES							
FAMILY HISTORY							



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REVIEW OF SYMPTOMS

PLEASE CHECK ANY SYMPTOMS THAT YOU ARE EXPERIENCING NOW OR HAVE EXPERIENCED IN THE PAST.

Chest Pain	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Currently Breast Feeding	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Numbness or Tingling	<input type="checkbox"/>
Epilepsy or Seizures	<input type="checkbox"/>	Bleed Easily	<input type="checkbox"/>	Headache	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Fever or Chills	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>
Nausea, Vomiting, Diarrhea	<input type="checkbox"/>	Limited Motion in Joints	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>
Unexpected Weight Loss or Gain	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	Genitourinary Problems	<input type="checkbox"/>
Sinus Disorder	<input type="checkbox"/>	Gastrointestinal Problems	<input type="checkbox"/>		<input type="checkbox"/>

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please Print Name of Patient, Parent Guardian or Personal Representative

Relationship to Patient