Please print in BLACK INK only.

NAME ____________________ DOB ____________ AGE ____________ DATE ____________

Primary Care Physician ____________________ Primary Care Phone ____________________

Primary Care Address ____

Pharmacy Name & Cross Street ____

Specialist(s) ____

Height ____________ Weight ____________

ALLERGIES/DRUG SENSITIVITY ____________________

PRESCRIPTION MEDICATIONS ____________________

NON-PRESCRIPTION MEDICATIONS / VITAMINS / SUPPLEMENTS / HERBAL PREPARATIONS ____________________

AVERAGE # OF ALCOHOLIC DRINKS PER WEEK ________

SMOKING HISTORY

❑ NO ❑ YES ______ PACK(S) / PER DAY ______ YEARS

QUIT WHEN? ____________________

❑ ARE YOU USING ❑ E-CIGARETTE ❑ NICOTINE GUM LOZENGE/PATCH

PREVIOUS SURGERY (INCLUDING COSMETIC SURGERY)

OPERATION	YEAR

ANESTHESIA PROBLEMS

Any problems with the surgery or the anesthesia?	YES	NO
History of nausea with surgery or medications?	YES	NO
Malignant Hyperthermia	YES	NO

Have you been admitted to a hospital within the past year?
❑YES ❑ NO EXPLAIN ____________________

Have you had an infection or been prescribed antibiotics in the past year? ❑YES ❑NO EXPLAIN ____________________

Have ever been diagnosed with a MRSA or VRE infection?
❑ YES ❑ NO When? ____________________

CARDIOVASCULAR

	YES	NO
Heart attack	☐	☐
Chest pain	☐	☐
Pacemaker/Defibrillator	☐	☐
Ankle swelling	☐	☐
Palpitations	☐	☐
Irregular pulse	☐	☐
Muscle pain/cramps	☐	☐
Heart murmur / Arrhythmia	☐	☐
Abnormal EKG	☐	☐
High blood pressure	☐	☐

HEAD, EYES, EARS, NOSE, THROAT

	YES	NO
Hearing Loss	☐	☐
Uncorrectable vision loss	☐	☐
Fever Blisters/Cold Sores	☐	☐
Swallowing difficulty	☐	☐

RESPIRATORY

	YES	NO
Recent Respiratory Infection	☐	☐
Asthma	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐
Chronic cough	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
Sleep Apnea / CPAP?	☐	☐

BREASTS

	YES	NO
Breast cancer	☐	☐
Lumps	☐	☐
Cysts	☐	☐
Previous biopsy	☐	☐
Previous mammogram	☐	☐

Date ____________________

GASTROINTESTINAL

	YES	NO
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcer	☐	☐
Hiatal hernia	☐	☐
Pancreatitis	☐	☐
Vomiting blood	☐	☐
Colitis	☐	☐
Unusual change in bowel habits	☐	☐
Blood in stool	☐	☐
Hemorrhoids	☐	☐
Gastric Bypass	☐	☐

GENITOURINARY

	YES	NO
Have you had recent infection in:		
bladder	☐	☐
kidneys	☐	☐
tubes	☐	☐
Stones in urine	☐	☐
Blood in urine	☐	☐
Incontinence or leakage of urine	☐	☐
Blockage of urine	☐	☐
Prostate problem	☐	☐

Last menstrual period ____________

NEUROLOGICAL

	YES	NO
Stroke/TIA	☐	☐
Migraine	☐	☐
Blackout spells	☐	☐
Dizziness	☐	☐
Weakness or paralysis	☐	☐
Motion/Car "Sickness"	☐	☐

MUSCULOSKELETAL

	YES	NO
Fractures	☐	☐
Dislocations	☐	☐
Joint pain	☐	☐
Arthritis	☐	☐
Back pain	☐	☐
Neck Stillness / Immobility	☐	☐

BLOOD/LYMPHATIC

Do you have or have you had:	YES	NO
Bleeding disorder	☐	☐
Anemia	☐	☐
Enlarged nodes	☐	☐
Transfusions	☐	☐
HIV	☐	☐
MRSA/VRE	☐	☐

ENDOCRINE

Do you have or have you had:	YES	NO
Diabetes	❑	❑
Thyroid problems	❑	❑
Pituitary problems	❑	❑

*PLEASE EXPLAIN '**YES**' ANSWERS.*

COMMENTS / EXPLANATIONS: ____________________

FAMILY HISTORY

Have any member of your family had:	YES	NO
Heart disease	☐	☐
High blood pressure	☐	☐
Diabetes	☐	☐
Cancer	☐	☐
Complications with surgery	☐	☐

COMMENTS / EXPLANATIONS: ____________________

Please complete back page.

PATIENT ABILITY TO HEAL:

DOES YOUR SKIN APPEAR FRAGILE/BURNS EASILY? ❑ YES ❑ NO

DO YOU FORM THICK OR RAISED SCARRING (KELOID) FROM A CUT OR BURN? ❑ YES ❑ NO

DO YOU WAX OR USE DEPILATORIES ON YOUR FACE? ❑ YES ❑ NO

ARE YOU SENSITIVE TO ADHESIVE TAPE? ❑ YES ❑ NO

DO YOU HAVE A LATEX SENSITIVITY? ❑ YES ❑ NO

SKIN CARE:

ARE YOU CURRENTLY USING ANY SKIN CARE PRODUCTS? ❑ YES ❑ NO

IF YES, WHAT PRODUCTS ARE YOU USING? ____

WHAT IS YOUR SKIN TYPE? ❑ DRY ❑ OILY ❑ COMBINATION ❑ SENSITIVE ❑ ROSACEA ❑ NORMAL

WOULD YOU LIKE INFORMATION REGARDING SKIN CARE PRODUCTS WE RECOMMEND? ❑ YES ❑ NO