PLANO AESTHETICS

Medical History Form

Date: _____

Name: _____ Height _____ Weight _____

DOB: _____ Age: _____ Sex: M F Race: _____

At what weight would you feel comfortable to maintain?_____

Do you currently exercise? If so, what type? How often? _____

List your current diet regimen (Adkins, HCG, etc.) If none, describe diet_____

Allergies and/or Sensitivities to Medications and/or Food: (Penicillin, Sulfa, Latex, Eggs, Shellfish, etc.)

Name of Allergy/Sensitivity	Description of Reaction	Reaction: Mild/ Moderate/ Severe	When/How was allergy identified?

If you do not have any allergies/sensitivities, ***please write NONE in a box above.***

Current Medications and/or Supplements (fish oil, multi-vitamin, birth control, over-the-counter meds, etc.)

Medication/ Supplement Name	Dosage/ Frequency/ Route (Pill, Injection, Cream)	What is the medication used for?	Name of physician that prescribed medication

If you are not taking any current medications and/or supplements, ***please write NONE in a box above.***

Patient Signature _____ DOB: _____ Date _____

How many alcoholic beverages do you consume per week? _____

Do you use tobacco products? How often? _____

What is your current method of birth control? (IUD, birth control pills, hysterectomy, etc.)_____

Have you had any Family History of breast cancer, prostate cancer, diabetes, heart disease, bleeding disorders, etc.?

Yes or No If Yes, Please list here: _____

Have you ever been hospitalized or had any surgery? Yes or No

If Yes, please give a brief description of surgery. *(Include any cosmetic, emergency, or elective surgery)*

Year	Diagnosis	Type of Surgery	Outcome

Past Medical History - Have you ever had any of the following?

_____ **Skin cancer**	_____ **High blood pressure**	_____ **Heart failure**
_____ **Breast cancer**	_____ **Are you on blood thinners?**	_____ **Heart murmur**
_____ **Prostate Cancer**	_____ **Pulmonary embolism**	_____ **Artificial heart valve**
_____ **Depression/Anxiety**	_____ **Deep Vein Thrombosis**	_____ **Rheumatic fever**
_____ **Diabetes**	_____ **EKG/Echocardiogram**	_____ **Stroke**
_____ **Wound healing problems**	_____ **Peripheral vascular disease**	_____ **Seizure/ Epilepsy**
_____ **Thyroid Disease**	_____ **Arthritis**	_____ **Meningitis**
_____ **High Cholesterol**	_____ **Heart attack**	_____ **Asthma**
_____ **Emphysema**	_____ **Bronchitis**	_____ **Tuberculosis**
_____ **Liver disease**	_____ **Pancreatitis**	_____ **Gout**
_____ **Pneumonia**	_____ **GERD**	_____ **Intestinal/ bowel disease**
_____ **Joint replacement**	_____ **HIV or AIDS**	_____ **Hepatitis**
_____ **Back pain**	_____ **Kidney disease**	_____ **Cataracts**

Please list all medical problems not included in above checklist…

_____

_____

Patient Signature _____ DOB: _____ Date _____

Review of Systems: Please Check Any That Apply

Ears, Nose, and Throat
- _____ Hearing Loss
- _____ Ringing in Ears
- _____ Altered Sense of Smell
- _____ Trouble Swallowing
- _____ Neck Pain/ Stiffness

Lungs
- _____ Nonproductive Cough
- _____ Pain with Breathing at Rest
- _____ Pain with Breathing with Exertion
- _____ Pain with Inspiration
- _____ Wheezing
- _____ Coughing up Blood
- _____ Short of Breath with Exertion

Cardiovascular System
- _____ Chest Pain/Pressure at Rest
- _____ Chest Pain/ Pressure with Exertion
- _____ Heart Palpations
- _____ Normal Tolerance to Exercise
- _____ Pain in Legs with Walking
- _____ Cold Hands/Feet
- _____ Fainting
- _____ Lightheadedness

Hematology (blood)
- _____ Anemia
- _____ Hemochromatosis

Musculoskeletal System
- _____ Joint Pain (any Joint)
- _____ Pain in any Muscles
- _____ Muscle Weakness

General Constitution
- _____ Fatigue
- _____ Night Sweats
- _____ Weight Loss
- _____ Weight Gain

Allergic
- _____ Hives

Neurological System
- _____ Headache
- _____ Loss of Sensation in any Part of Body
- _____ Weakness of any Extremity
- _____ Uncontrolled Muscle Movements
- _____ Dizziness
- _____ Problems with Walking
- _____ Speech Disturbance

Genitourinary System
- _____ Pain with Urination
- _____ Urinary Frequency
- _____ Urinary Urgency
- _____ Blood in Urine
- _____ Trouble Starting Stream
- _____ Difficulty Stopping Stream
- _____ Erectile Dysfunction

Integumentary (Skin) System
- _____ Rashes
- _____ Psychiatric
- _____ Depressed
- _____ Anxious/Nervous

Endocrine
- _____ Goiter (Lump in Neck)
- _____ Appetite Change
- _____ Heat or Cold Intolerance

Eyes
- _____ Headache
- _____ Blurry Vision
- _____ Double Vision
- _____ Visual Changes

Gastrointestinal System
- _____ Pain with Swallowing
- _____ Abdominal Pain
- _____ Nausea
- _____ Vomiting

Patient Signature _____ DOB: _____ Date _____