Please print in BLACK INK only.

NAME _____ DOB _____ AGE _____ DATE _____

Primary Care Physician _____ 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