



Health Information Form

Name _____ Age _____ DOB _____ Date _____

Primary Care Physician Name _____ Location _____

Reason for your visit today: _____

Are you **allergic to any medications?** **NO**___ **YES**___ If yes, please list medication and your reaction: _____

Do you have a history of any of the following conditions? (please circle yes or no)

- YES NO Heart attack or other heart disorders
- YES NO Pacemaker and/or Defibrillator..... Cardiologist Name/Phone
- YES NO Stroke or other brain disorders _____
- YES NO High/Low blood pressure
- YES NO Blood Clots or Thrombosis
- YES NO Pulmonary Embolus
- YES NO Pneumonia/Tuberculosis
- YES NO Shortness of Breath
- YES NO Asthma/Emphysema
- YES NO Hay fever/Allergies
- YES NO Rheumatic fever
- YES NO Fainting/Dizziness/Headaches
- YES NO Convulsions/Epilepsy
- YES NO Anxiety/depression or psychiatric disorder
- YES NO Cancer chemotherapy
- YES NO Diabetes/Thyroid or other gland disorders
- YES NO Anemia or other blood disorders
- YES NO Kidney/Liver disorders
- YES NO Stomach/Intestine disorders
- YES NO Bone/Joint disorders
- YES NO Skin/Hair disorders
- YES NO Sciatica/Carpal tunnel or other nerve disorders
- YES NO Eyes/Ears/Sinus disorders
- YES NO Fibromyalgia, Chronic fatigue or other muscle disorders
- YES NO HIV or other infectious diseases
- YES NO Pain Pills or Shots
- YES NO Do you or your family members have a history of MRSA?
- YES NO Have you ever had excessive bleeding after surgery or dental work?
- YES NO In the event of a life saving emergency associated with your surgery, are you opposed to receiving a blood transfusion?

For Clinical Staff:
Obtain copy of Pacemaker card _____(init)

Do you have any other illnesses not mentioned _____

Please list all current medications (Prescription and Over-the-Counter)

Please list any current Herbs, Vitamins or Food Supplements you are taking:

Do you have a history of cold sores, herpes or similar lesions? _____

List any previous surgeries (include cosmetic procedures/injuries/childbirth/hospital admissions)

Have you ever experienced problems with anesthesia? _____

Females:

Are you pregnant? _____ Number of Pregnancies: _____ Number of Children _____

Breast Surgery consultation Only:

Bra Size _____ Size you would like to be: _____

Do you do breast self-examinations on a regular basis? _____

Do you have a family history of Breast Cancer? _____

Do you have a history of breast problems (i.e., cysts, lumps, etc)? _____

If so, what problems? _____

When was your last mammogram? _____

Do you have any of the following (Y or N):

Headaches _____ Back pain _____ Neck pain _____ Breast Pain _____

Shoulder pain _____ Skin problems under your breast _____

Health Habits:

How often do you exercise? Type/frequency) _____

Are you aware of any stress eating or eating disorders (Describe)

Do you smoke? _____ If so, how much? _____

Are you exposed to 2nd hand smoke? _____

Do you drink alcohol? _____ If so, how much? _____

Do you take any recreational drugs? (list) _____

What is your current skin care regimen? _____

Are you satisfied with this? _____

Is there anything else we should know about you? _____

Signature: _____ Date _____