

Name _____ DOB _____ Date _____

Reason for your visit today: _____

Do you have a history of any of the following conditions?

- YES NO Heart attack or other heart disorders
- 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?

Do you have any other illnesses not mentioned? _____

Date of last Chest X-Ray: _____ Date of last EKG: _____

Are you **allergic to any medications, food, and/or products?** _____ If yes, please list _____

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 _____

Skin Care Patients Only:

Which body are/areas or conditions would you like treated? _____

YES NO Are you currently using any topical prescriptions? _____

YES NO Do you have a history of keloid/hypertrophic scarring? _____

YES NO Have you taken Accutane or anticoagulants (blood thinners) in the last 6 months? _____

YES NO Have you had any unprotected sun exposure, used tanning creams or used tanning beds in the last 4 – 6 weeks? _____

YES NO Do you have any permanent make-up, implants or tattoos? _____

If yes, please list locations: _____

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? _____

What is your current skin care regimen? _____

Are you satisfied with this? _____

Is there anything else we should know about you? _____

Signature: _____ Date _____