Patient History Questionnaire

NAME: ______________________ AGE: ________ BIRTHDATE: ______

SEX (Male / Female) HEIGHT: ______ WEIGHT: __________ SSN: ______________

ADDRESS: ______________________

CITY: ______________ STATE: ________ ZIP CODE: __________

E-MAIL ADDRESS: ______________________ (Great way to receive our coupons and specials.)

HOME PHONE: __________ WORK PHONE: __________ CELL PHONE: __________

* Please circle the best way to contact you on the options above

PERSONAL PHYSICIAN: ______________________

HOW DID YOU HEAR ABOUT US? ☐ Internet ☐ Radio ☐ T.V. ☐ AD ☐ Friend or Family ☐ Event ☐ Drive by

PERSON WHO REFERRED YOU: ______________________

EMERGENCY CONTACT PERSON PHONE #: ______________________

REASON FOR TODAY'S VISIT ______________________

PARTS OF BODY TO BE TREATED ______________________

PATIENT MEDICAL HISTORY : ANSWER YES OR NO TO THE FOLLOWING. IF ANSWERED YES, PLEASE CIRCLE AND EXPLAIN UNDER COMMENTS.

NO	YES	
___	___	PREVIOUS LIPOSUCTION / FACE LIFT / OTHER COSMETIC SURGERIES
___	___	CONSTITUTIONAL (Fever, weight loss, night sweats)
___	___	CARDIOVASCULAR (Heart attack, stroke, chest pain, valve disease)
___	___	RESPIRATORY (Emphysema, asthma, tuberculosis)
___	___	ENDOCRINE (Diabetes, thyroid)
___	___	VIRAL (Herpes, HIV)
___	___	MUSCULOSKELETAL (Previous fracture, muscle or bone disease, arthritis)
___	___	INTEGUMENTARY (Psoriasis, eczema)
___	___	PSYCHIATRIC (Depression, anxiety)
___	___	HEMATOLOGIC (Anemia, bleeding tendency)
___	___	GENITAL/URINARY (Infection, kidney stones, prostate)
___	___	GASTROINTESTINAL (Ulcer, gastritis, colitis)
___	___	EYES (Glaucoma, cataract)
___	___	EARS/NOSE/MOUTH/THROAT
___	___	NEUROLOGICAL (Seizures, numbness, tremors)
___	___	OTHER PROBLEMS (High cholesterol or blood pressure, cancer)

COMMENTS: ______________________

____

____

PAST MEDICAL HISTORY:

Previous operations – cosmetic or health related:

___

Issues with Anesthesia? Y/N If yes, please explain: ___

___

Allergies to medications:

___

Current medications, vitamins and supplements and their dosage:

1) ___ 4) ___

2) ___ 5) ___

3) ___ 6) ___

FAMILY HISTORY:

Has anyone in your family had any of the following illnesses? If yes, please identify the family member.

YES	NO		If yes, circle?
___	___	Lung disease/asthma/emphysema	Mother / Father Sister / Brother Grandparent
___	___	Heart disease, heart attack	Mother / Father Sister / Brother Grandparent
___	___	High blood pressure	Mother / Father Sister / Brother Grandparent
___	___	Diabetes	Mother / Father Sister / Brother Grandparent
___	___	Cancer	Mother / Father Sister / Brother Grandparent
___	___	Arthritis	Mother / Father Sister / Brother Grandparent

Other ___

SOCIAL HISTORY:

Marital status ___S___M___W___D If married, spouse's name: ___ Contact # ___

How many children? ___ Ages? ___

Is there any possibility that you may be pregnant at this time? YES NO

Current employer: ___

Job description: ___

Do you smoke cigarettes? ___ If yes, how many packs per day? ___ How long? ___

Do you drink alcohol? ___ If yes, how many days per week? ___ Drinks per day? ___

Do you have a current or past history of substance abuse? ___

If yes, please explain ___

Patient/Legal Guardian Signature: ___ **Date:** ___

Physician Signature: ___ **Date:** ___

NO SHOW POLICY:

Your appointment time has been specially reserved for you, should you be unable to keep your appointment a minimum of 24 hours' notice is appreciated. Failure to give adequate notice may result in a minimum charge of $75 and / or full prepayment of your next booking which will be non-refundable. If a treatment package appointment is missed without 24 hours' notice, you will forfeit that day's treatment. We will hold a credit card on file for your convenience and to secure appointments. It is kept in a password protected location.

Please Read & Initial: ___

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____

Signature of Patient or Personal Representative

____

Printed Name of Patient or Personal Representative

____

Date