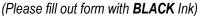
HEALTH HISTORY FORM





DOB: _____ Are you currently under the care of a physician? Yes | No Height: _____ | Weight: _____ Name of Physician: Date of Last EKG: __ Do you smoke or use tobacco? Yes | No Do you have any allergies to medicine? Yes | No Daily Amount: _____ | Weekly: _____ Please List: Do you smoke marijuana? Yes | No Daily Amount: _____ | Weekly: _____ Do you vape? Yes | No Daily Amount: ____ | Weekly: ____ Do you drink alcoholic beverages? Yes | No Are you allergic to Latex? Yes | No Daily Amount: _____ | Weekly: _____ Are you allergic to Tape? Yes | No Have you ever been addicted to drugs or alcohol? Yes | No List any Surgeries (including cosmetic) you've had & date: Explain: Do you wear contact lenses? Yes | No List all Medications you are currently taking, include Do you bleed easily from cuts or surgery? Yes | No Have you ever had problems with anesthetic? Yes | No Non-Prescription, Vitamins, Herbals & Supplements: Have you ever tested positive for HIV? Yes | No Have you ever taken **Accutane**? Yes | No Date last taken: _____ For Women: Have you ever consulted a psychiatrist or psychologist or Are you pregnant? Yes | No been prescribed medication by them? Yes | No Are you lactating? Yes | No YOU CANNOT HAVE SURGERY IF YOU ARE PREGNANT If yes, explain and include medications prescribed: Number of Pregnancies: _____ | Deliveries: _____ Date of last Mammogram: ____ DO YOU PRESENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING: Y N Hepatitis Y N Herpes Y N Abnormal Bleeding Y N Cold Sores Y N Pulmonary Embolism Y N AIDS Y N Congenital Heart Defect Y N Radiation Treatment Y N Depression Y N Rheumatic Fever Y N High Blood Pressure Y N Anemia Y N Arthritis Y N Irregular Heart Beat Y N Diabetes Y N Seizures Y N Artificial Valves Y N Difficulty Breathing Y N Kidney Problems Y N Sinus Problems Y N Liver Problems Y N Asthma Y N Deep Vein Thrombosis Y N Sleep Apnea Y N Low Blood Pressure Y N Bipolar Disorder Y N Emphysema Y N Stroke Y N Lupus
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Lupus
Y N Mental Illness
Y N Mitral Valve Prolapse
Y N Glaucoma Y N Swollen Ankles Y N Cancer Y N Chemotherapy Y N Thyroid Problems Y N Chest Pains Y N Tonsillitis Y N Cholesterol Y N Tuberculosis (TB) Y N Chronic Fatigue Syndrome Y N Heart Problems Y N Persistent Cough Y N Ulcers Y N Clotting Problems Y N Hemophilia Y N Polycystic Ovaries Y N Venereal Disease Any additional information: I affirm that the information I have given is correct to the best of my knowledge, it will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status.

Date

Patient Signature