

## MEDICAL & PERSONAL HISTORY

Name: _____	Date: _____
Drivers License #: _____	Birth Date (mm/dd/yyyy): ____/____/____
Address: _____	City: _____ St: _____ Zip: _____
Phone: (Home) _____	(Work) _____ (Cell) _____
E-mail Address: _____	
Emergency Contact: _____	Phone: _____

Main reason for today's visit: \_\_\_\_\_

Other Concerns: \_\_\_\_\_

**MEDICATIONS:** Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

<u>Medication</u>	<u>Dose (e.g., mg/pill)</u>	<u>Reasons For Each</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies or reactions to medications and/or creams: \_\_\_\_\_

**PERSONAL MEDICAL HISTORY:** Please indicate whether you currently have or have had any of the following medical conditions (with dates).

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Acne                       | <input type="checkbox"/> Recent Fever/Cold/Flu | <input type="checkbox"/> Lipomas (Fatty Tumors)                   |
| <input type="checkbox"/> Auto-Immune Disease        | <input type="checkbox"/> Gastrointestinal      | <input type="checkbox"/> Neurological                             |
| <input type="checkbox"/> Cardiac Disease            | <input type="checkbox"/> Hypertension          | <input type="checkbox"/> Organ Transplant                         |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Psychiatric                              |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Kidney Disorders      | <input type="checkbox"/> Recent Weight Gain                       |
| <input type="checkbox"/> Eating Disorder            | <input type="checkbox"/> Liver Disorders       | <input type="checkbox"/> Recent Weight Loss                       |
| <input type="checkbox"/> Epilepsy/Seizure Disorders | <input type="checkbox"/> Lymphatic Disorders   | <input type="checkbox"/> Skin Conditions (i.e. rash, sensitivity) |

If you have checked any of the boxes in the Personal Medical History section, please describe what steps have been taken to treat these conditions:

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**SURGICAL HISTORY:** Please list all prior operations (with dates):

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1. As a result of any surgeries, do you have any metal implants? **YES / NO**

If yes, please explain where: \_\_\_\_\_

2. Do you have any open wounds or present burns in the area you are requesting treatment? **YES / NO**

3. Do you have feeling, both superficially and deeply in the area you are requesting treatments? (This is very important, because patient feedback is necessary to achieve safe and effective results.) **YES / NO**

4. Do you currently have any electrical support systems in your body (i.e. pacemakers, automatic defibrillator, cardioverter)? **YES / NO**

If yes, please list: \_\_\_\_\_

5. Do you have any other type of implantable devices? **YES / NO**

If yes, please list: \_\_\_\_\_

**COSMETIC HISTORY:**

1. Have you had any cosmetic procedures performed in the area you are seeking treatment? **YES / NO**

If yes, please explain: \_\_\_\_\_

2. Have you had any complications as a result of any cosmetic procedure(s): **YES / NO**

If yes, please explain: \_\_\_\_\_

3. Have you recently had any Botox or soft tissue fillers (i.e. Restylane, Juvederm) in the area you are requesting treatment? **YES / NO**

If yes, when was the date of your last treatment(s)? \_\_\_\_\_

**PREGNANCY & CONTRACEPTIVES:**

1. Are you currently menstruating? **YES / NO**
2. If you are a women, are you currently pregnant, or is there a possibility that you are pregnant? **YES / NO**
3. Are you currently trying to get pregnant? **YES / NO**
4. Are you currently on birth control? **YES / NO**
5. Are you currently breast feeding? **YES / NO** If yes, please list: \_\_\_\_\_
6. If you have delivered a child, what type of delivery did you have? **Cesarean Section / Vaginal**
7. Do you have a Tubal Ligation? **YES / NO**
8. If you have had tubal ligation, what material is your clip made of? **Titanium / Plastic**
9. Do you have an IUD? **YES / NO**
10. If yes, which of the following material does it contain? **Copper / Hormones**

**SOCIAL HISTORY:**

1. Are you currently using or do you have a history of tobacco use? **YES / NO**
2. If yes, please list: packs/day \_\_\_\_\_ Other: \_\_\_\_\_ No. of years: \_\_\_\_\_
3. Are you currently using or do you have a history of illegal drug use? **YES / NO**
4. Please describe your alcohol consumption:  
**Daily / Weekly / Monthly / Occasionally / Rarely / Never**
5. Please describe your caffeine intake: **None / Coffee / Tea / Soda** \_\_\_\_\_ cups/day

**OTHER:**

**Are you being treated for any other conditions not listed? If so, please explain:**

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**Is there any other information that you feel may be related to or is pertinent to your treatment? If so, please explain.**\_\_\_\_\_

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**(Patient Signature)**

**(Date)**