Patient History Questionnaire

NAME: _____ AGE: _____ BIRTHDATE:_____

ADDRESS: _____ SEX (M/F) HEIGHT: _____ WEIGHT:_____

CITY: _____ STATE: ____ ZIP CODE: _____ **Home/or cell #** _____

E-MAIL: _____

PERSONAL PHYSICIAN: _____
EMERGENCY CONTACT PERSON & PHONE NUMBER: _____

REASON FOR TODAY'S VISIT: _____
PART OF BODY TO BE TREATED: _____
REFERRED BY (FOUND OUT ABOUT) PROGRAM: _____

PATIENT MEDICAL HISTORY (REVIEW OF SYSTEMS)
ANSWER YES OR NO TO THE FOLLOWING. IF ANSWERED YES, PLEASE EXPLAIN BELOW

NO	YES	
___	___	PREVIOUS LIPOSUCTION / FACE LIFT / OTHER COSMETIC SURGERIES
___	___	CONSTITUTIONAL (Fever, Weight loss, Night sweats)
___	___	CARDIOVASCULAR (Heart attack, Stroke, Chest pain, Valve disease Heart Congestion)
___	___	RESPIRATORY (Emphysema, Asthma, Tuberculosis, Lung Insufficiency)
___	___	ENDOCRINE (Diabetes, Thyroid)
___	___	VIRAL (Herpes, HIV)
___	___	MUSCULOSKELETAL (Previous fracture, Muscle or Bone disease, Arthritis)
___	___	INTEGUMENTARY (Psoriasis, Eczema Skin Inflammation)
___	___	PSYCHIATRIC (Depression, Anxiety)
___	___	HEMATOLOGIC (Anemia, Bleeding tendency)
___	___	GENITAL/URINARY (Infection, Kidney stones, Prostate Kidney Insufficiency)
___	___	GASTROINTESTINAL (Ulcer, Gastritis, Colitis)
___	___	EYES (Glaucoma, Cataract)
___	___	EARS (Chronic Tinnitus or Meniere' Syndrome vertigo or dizziness)
___	___	NEUROLOGICAL (Seizures, Numbness, Tremors)
___	___	Infections
___	___	Varicose Veins and Capillaries
___	___	Thrombophlebitis or History of Deep Vein Thrombosis
___	___	OTHER PROBLEMS (High cholesterol or blood pressure, Cancer or Tumors of any origin)
___	___	History of any Surgery

If Yes Please Explain: _____

_____

_____

_____

Current medications and dosages:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Allergies to Medication: _____

Family History:
Yes or No if yes, who?

___ ____ Lung Disease / Asthma/ Emphysema _____
___ ____ Heart Disease / Heart Attack _____
___ ____ High Blood Pressure _____
___ ____ Diabetes _____
___ ____ Cancer _____
___ ____ Arthritis _____
___ ____ Other_____

Social History
Marital Status___s___m___w___D if married, spouse's name_____

How many children_____ ages_____

Current employer_____

Job Description_____

Occupational history_____

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 past history of substance abuse_____

If yes, please explain_____
Please list your hobbies, sports, interests_____

Patient/legal Guardian Signature: _____

Date: _____

Physician signature: _____

Date: _____