

Patient Health History Form

In order for us to obtain a comprehensive medical history, it is important for you to fill out this form completely.

Today's Date _____ Full Name _____ DOB: _____

Please circle the following concerns that apply to you.

Aging Face Nasal Shape Wrinkles Sunspots Volume Loss Hair Loss Eye Lids Chin Shape

Other not listed above _____

Have you ever been diagnosed with any major medical problem? YES NO

Medical Condition

Year Diagnosed

Have you had any previous surgeries either medical or cosmetic? YES NO

Type of Surgery

Date of Surgery

Are you taking ANY kind of medication now? (This includes rx, over the counter, herbal) YES NO

Medication Name

Dosage

ALLERGIES: Please list all allergies whether medication, food, or environmental

Allergy

Type of reaction

Do you use tobacco? Yes No If yes what type? _____ How Often _____

Do you consume alcohol? Yes No If yes what type? _____ How Often _____

Do you use recreational drugs? Yes No If yes what type? _____ How Often _____

Review of Systems: Have you had any problems recently in the following areas. (Circle all that apply)

Head/Neck Eyes Ears Nose/Sinus Mouth/Throat Heart Lungs/Respiratory Digestive
 Female Health Bone/Joint Skin Brain Mental Blood Allergies Hormone

Explain: _____

(Women only) Are you pregnant? Yes No

I certify that all the information is accurate.

 Patient Signature