PLEASE COMPLETE THE ENTIRE FORM

Name: ____ **Today's Date:** ________________

Height: _____________ **Weight:** _____________ **Date of birth:** __________________

Please tell us your main concerns that brought you to our office today: ___________________________________

____

Please check any health problems, past or present:

☐ Seizures	☐ Liver disease	☐ Cancer (Type: _________)	☐ Stomach problems	☐ Migraines
☐ Hormonal Problems	☐ Diabetes	☐ Cystic Acne	☐ Thyroid	☐ Asthma
☐ High Blood Pressure	☐ Heart problems	☐ Cold sores/Herpes	☐ Kidney disorder	☐ Hepatitis
☐ Fainting	☐ HIV/ARC/AIDS	☐ Lupus, scleroderma	☐ Psychiatric problems	
☐ Blood clots	☐ Ankle swelling	☐ Shortness of breath	☐ Keloid scars	☐ Weight loss

☐ Other: ____

Please list any previous surgical procedures: ____

____

____

Family history of medical conditions (e.g. cancer) Please list: ____

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Please answer yes or no to the following questions and list details:

YES	NO	
☐	☐	Do you have any history of substance abuse?
☐	☐	Do you have a personal or family history of Malignant Hyperthermia?
☐	☐	Are you using any prescribed medications, (including topical medicines for acne or pigmentation)? List____
☐	☐	Are you using any Herbal medications? List____
☐	☐	Are you allergic to any medications, cosmetic ingredients, foods or latex? List _______________ ____
☐	☐	Are you pregnant or trying to become pregnant?
☐	☐	Do you use oral contraceptives?
☐	☐	Do you use hormone replacement therapy?
☐	☐	Do you smoke? How much? _____________ How long? _____________
☐	☐	Have you had a mammogram? When? ___________ Where? _______________ Result? __________

May we send a copy of our note to your primary care or referring physician? Yes______ No_______

I certify that the above information is correct to the best of my knowledge. ______________________________
Patient's Signature

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