PERSONAL AND FAMILY HEALTH HISTORY

Name:_____ **Date:**_____ **DOB:**_____

Reason for visit: _____

_____

Do you currently experience any of the following:

	YES	NO
Anxiety		
Arthritis		
Asthma		
Bleeding Tendency		
Chest Pain/Angina		
Diabetes		
Difficulty Swallowing		
Excessive Scarring		
GI Problems		
Hay Fever		
High/Low Blood Pressure		
Itchy Eyes		
Migraine		
Poor Wound Healing		
Serious Depression		
Wheezing		

Current Medications: _____

_____

_____

_____

_____

Take Asprin Daily? Yes No

Medicine Allergies / Latex Allergy:

_____

_____

_____

HEIGHT: _____

WEIGHT: _____

Occupational:	YES	NO
Work Indoors		
Work Outdoors		

Do you wear any artificial devices? Yes No

List: _____

_____

Past Medical History:

	YES	NO
Acne		
Clotting/Bleeding Problems		
Diabetes		
Heart Disease		
Hepatitis		
HIV		
Hypertension		
Mental Illness		
Reactions to Anesthesia		
Rosacea		
Skin Cancer **BCC/SCC/MM**		

Hospitalizations / Reason Date: _____

_____

_____

_____

Social History: If yes, daily amount

	YES	NO	Amt.
Alcohol			
Drink Coffee			
Recreational Drug Use			
Tanning Bed Use			
Tobacco			

Operations:

	YES	NO
Appendix		
Colon		
Gall Bladder		
Hernia		
Defibrillator/Pace Maker		
Stomach		
Thyroid		
Tonsils		
Breast **Biopsy/Augmentation**		
Uterus		
Overies		
Prostate		

Other:_____

Family History Of:

	YES	NO
Autoimmune Disease		
Eczema		
Melanoma		
Psoriasis		
Skin Cancer		

Relation: _____

PATIENT SIGNATURE: _____

Date: _____