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MEDICAL QUESTIONNAIRE

Name_____Birthdate_____Today's Date_____

Address: Home_____(_____)_____
Street City State Zip Phone
Business_____(_____)_____
Street City State Zip Phone

Occupation_____Marital Status: S, M, D, W, Separated

Spouse's Name_____ Ages of Children_____

Email Address: _____Cellular Number:(_____)_____

Are you interested in aesthetician services? YES NO If so, what service_____

How were you referred to us? _____

What are you being seen for today?_____

Have you had other prior surgery? (What was done and when was it performed?)
In the head and neck area?_____On your skin?_____
On your teeth or gums?_____ In your chest?_____
In your abdomen?_____On the reproductive system?_____
On your back, arms, or legs?_____ Were there any complications?_____
Did you have a normal recovery?_____Were you satisfied with the results?_____
If not, why?_____

MEDICAL HISTORY

NO YES Are you taking any drugs or medications? (How often?)

List them_____

NO YES Are you allergic to any medications?

List them_____

When was your last physical examination?_____

Who is your family doctor?_____

Address_____Phone _____

NO YES Would you object to our contacting him/her in regard to any medical problem that might arise?
NO YES Have you ever received local anesthesia (Novacaine or Xylocaine) by a dentist or doctor?
If so, any reaction?_____
NO YES Are you considered a healthy person?

PLEASE CONTINUE ON THE BACK

Do you or any family members have: (Indicate who)
Heart Trouble_____Excessive bleeding tendencies_____
Tuberculosis_____High blood pressure_____
Excessive bruising_____ Excessive scarring_____
Diabetes_____ Thyroid problems_____
Psychiatric or "nerve" problems_____
Do you have any history of bleeding:
From the nose_____In the urine_____Vomiting blood_____
From the rectum_____Coughing up blood_____Other_____
NO YES Do you have hay fever, nasal allergies or asthma?_____
NO YES Do you have or have you had any problems with your eyes?_____
NO YES Do you have frequent pains in the chest?
NO YES Do you have any blood pressure problems?_____
NO YES Has a doctor ever said you had "heart trouble" or irregular heartbeat?
NO YES Do you have "stomach trouble" or ulcers?
NO YES Do you get short of breath easily?
NO YES Do you have or have you had chest or lung problems?
NO YES Have you ever had liver, gall bladder trouble or "yellow jaundice?" (Circle)
NO YES Do you have any kidney disease?_____
NO YES Do you or any family members suffer from arthritis?
NO YES Do you have frequent skin infections, irritations or rashes? (Circle)
NO YES Do you often have severe headaches or dizzy spells? (Circle)
NO YES Has any part of your body ever been paralyzed or numb?_____
NO YES Have you ever had a convulsion or seizure?
NO YES Are you at a high risk for AIDS?
NO YES Have you ever had cold sores or fever blisters?
NO YES Are you frequently sick or ill?
NO YES Do you worry about your health?
NO YES Were you ever treated for anemia or any problems with your blood?_____
NO YES Have you ever taken hormones or thyroid medication? (Circle)
NO YES Do you smoke? How many cigarettes per day?_____
NO YES Do you drink more that 6 cups of coffee per day?
NO YES Do you usually take 2 or more alcoholic drinks a day?
NO YES Do you often get depressed?
NO YES Are you considered a nervous person?
NO YES Have you ever received medical treatment for a "nervous condition"?
NO YES Have you ever been under the care of a psychiatrist or psychologist?_____
Do you have any other medical problems that have not been covered?
Explain_____
WOMEN ONLY: When was your last menstrual period?_____
NO YES Are your periods often irregular? NO YES If applicable, is there a possibility of pregnancy at this time?
NO YES Have you had "female" or GYN problems?_____
MEN ONLY:
NO YES Have you ever had prostate problems?_____

Patient Signature_____**Date**_____