



HEALTH HISTORY FORM

Patient Name: _____ **Age:** _____

Please list the **primary reason for your visit** today: _____

Please list any prior treatment(s) you may have had for this condition: _____

Are there additional topics, procedures or concerns you would like to discuss today (providing there is adequate time)? If so, please list: _____

Have you ever had a medical condition that required hospitalization? () Yes () No

If yes, please explain: _____

Have you ever had surgery of any kind? () Yes () No

If yes, please explain: _____

List all current medications:

List any medications that cause you an allergic reaction and/or side effects:

Please list your height: _____ Weight: _____

Is there a possibility that you may be pregnant, or are you considering pregnancy? () Yes () No

Date of your last menstrual period: _____

Do you have a history of cold sores? () Yes () No

If yes, please list any medications you used: _____

Are you using, or have you ever used **Renova, Retin A, Alpha hydroxy** or **Glycolic Acid**? () Yes () No

If yes, please specify duration, strength and date of last use: _____

Are you using, or have you ever used **Accutane**? () Yes () No

If yes, please specify date of last use: _____

Are you currently having, or have you ever had **radiation therapy**? () Yes () No

If yes, please specify date and site: _____

Do you have any implants, tattoos, or permanent makeup in/on the area to be treated? () Yes () No

If yes, type/location: _____

Please check below if you have been diagnosed with any of the following conditions.

- Skin**
- Psoriasis
 - Skin Cancer
 - Abnormal Moles
 - Phlebitis/Blood Clots
 - Other:

- CV**
- Heart Attack/ Angina
 - Arrhythmia
 - Heart Murmur
 - Heart Failure
 - Other:

- Hematological**
- Anemia
 - Leukemia
 - Lymphoma
 - Blood Disease
 - Bleeding Tendencies
 - Easy Bruising
 - Other:

- Respiratory**
- Asthma
 - Shortness of Breath
 - Chronic Bronchitis/COPD
 - Currently Smoking
 - Other:

- Gastrointestinal**
- Ulcer
 - Irritable Bowel
 - Jaundice
 - Liver Disease
 - Colitis
 - Other:

- Infection**
- Herpes
 - HIV
 - Hepatitis
 - STD
 - Other:

- Musculoskeletal**
- Arthritis
 - Muscle Pain When Walking
 - Weakness
 - Extremity Fractures
 - Ankle Swelling
 - Other:

- OB/GYN**
- Number of Pregnancies:
 - Number of Births:
 - C-Section
 - Other:

- Genitourinary**
- Kidney Disease
 - Incontinence
 - Stones
 - Other:

- Endocrine**
- Diabetes
 - Thyroid Problem
 - Irregular Menses
 - Other:

- Allergic/Immunologic**
- Hay Fever
 - Cancer
 - Chemotherapy
 - Adverse Reaction to Local Anesthesia
 - Other:

- Neurological**
- Anxiety
 - Depression
 - Seizure
 - Multiple Sclerosis
 - Stroke/TIA
 - Other: