PATIENT HEALTH HISTORY FORM

Patient Name: _____ Date: _____

Age: _____ Sex: ☐M ☐F Height:___ Weight:_____ Medical Allergies: _____

Primary Care Physician: _____

CURRENT MEDICATIONS:

Drug Name	Reason for Taking

(Include Herbal & Over the Counter Medications)

SURGERIES/GENERAL ANESTHESIA:

Surgery Type	Approximate Year

REASON FOR VISIT: _____

HEALTH HISTORY

SELF	FAMILY
☐ Bleeding/Clots	☐
☐ Anesthesia Problem	☐
☐ Seizures/Fainting	☐
☐ Diabetes	☐
☐ Depression/Anxiety	☐
☐ Thyroid Disease	☐
☐ Anemia	☐
☐ Heart Disease	☐
☐ High Blood Press	☐
☐ Lung Disease	☐
☐ HIV/Aids	☐
☐ Kidney Disease	☐
☐ Asthma	☐
☐ Hepatitis	☐
☐ Cancer	☐
☐ NONE APPLY	☐

SOCIAL HISTORY

Tobacco Use:	☐ None	☐ Packs/day: _____	
Alcohol Use:	☐ Daily	☐ Occasional	☐ Never
Exercise:	☐ Daily	☐ Occasional	☐ Never
Sun Exposure:	☐ Minimal	☐ Moderate	☐ Excessive
Tanning Bed:	☐ None	☐ Frequency: _____	
Sunscreen Use:	☐ Daily	☐ Occasional	☐ Never

NOTES:

_____

_____

_____

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_____

WOMEN

Post Menopausal: ☐ Y ☐ N

Possibly Pregnant: ☐ Y ☐ N

Total # of Pregnancies: _____

Number of Children: _____

Current Bra Size: _____

Preferred Cup Size: _____

Last Mammo:_____

GENERAL

History of Poor Healing: ☐ Y ☐ N

Recent Weight Gain/Loss: ☐ Y ☐ N Amount +/-___ Over how long:____

Visual Health Concern: ☐ Y ☐ N Please specify: _____

MEN

Past/Present Steroid Use: ☐ Y ☐ N

History of Thick Scars: ☐ Y ☐ N

Testosterone Supplements: ☐ Y ☐ N