PATIENT HEALTH HISTORY FORM

Patient Name: ______________________________ Date: ________________

Age: ______ Sex: ☐M ☐F Height:______ Weight:______ Medical Allergies: ______________

Primary Care Physician: ______________________ Ethnicity ________________

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:

____
____
____
____
____
____
____
____

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
History of Thick Scars: ☐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
Testosterone Supplements: ☐Y ☐N