MEDICAL/SURGICAL HISTORY

Date: _____ Age: _____

1. Please state the nature of your current problem:_____

2. How long have you had this problem? _____

3. What area if the body does it mainly affect? _____

4. How severe is the condition that affects you? (Circle please) mild moderate severe

5. Has anything that you have used helped or worsened the condition? If so, please state:
_____

6. Do you have any problems with your digestive system? YES or NO If yes, please list
_____

7. Do you have any problems with your respiratory system? YES or NO If yes, please list
_____

8. Do you have any artificial joints, hip, knee or shoulder replacements, heart valves or other prosthetic devices in your body from surgeries? (Such as pins, plates or screws)? YES or NO If yes, please list
_____

9. Do you have a pacemaker or defibrillator or mitral valve prolapse? YES or NO If yes, please list
_____

10. Please list your current medications and any you have taken within the last month. Please include all over the counter medications and vitamins/herbs: _____
_____

11. Do any members of your family have hay fever, asthma, or eczema? YES or NO

12. Are you allergic to Penicillin, sulfa drugs, lidocaine, neomycin, tape adhesive, iodine, or any medications?
_____

13. Please list all surgeries you have had. Include the date please: _____
_____

14. Have you ever been treated for skin cancer? YES or NO If so, what kind/where? _____
15. Has anyone in your family been treated for skin cancer? If so what kind? _____
16. Do you have any bleeding or clotting disorders? YES or NO
17. If you smoke tobacco or drink more than two drinks of alcohol/day, please state how much. _____
_____
18. Are you ____HIV or ____Hepatitis Positive? YES or NO
19. Do you have any medical illness? (High Blood Pressure, Diabetes, etc.) If yes, please list.
_____

20. **FEMALES: IS THERE ANY CHANCE YOU ARE PREGNANT OR NURSING?** YES or NO

PATIENT OR GUARDIAN SIGNATURE: _____