CONFIDENTIAL MEDICAL HISTORY

Today's Date: _______________

Please enter your name, personal information and the date on BOTH pages.
If you answer "YES" to a particular question, please mark all of the options that apply.

Patient Name: **Date of Birth:** **Age:** **Sex:** **Height:** **Weight:**

Reason for today's visit:

Do you have an advanced directive or living will? ❑ NO ❑ YES

1. Do you have PROBLEMS breathing while lying flat: ❑ NO ❑ YES ❑ UNSURE

2. Do your legs, ankles, feet or toes swell easily or frequently? ❑NO ❑ YES ❑ UNSURE

3. Are you taking ASPIRIN product? How much? ❑ NO ❑ YES

4. Have you ever had a HEART condition, HEART ATTACK, or HIGH BLOOD PRESSURE? ❑ NO ❑ YES ❑ UNSURE

❑ Heart attack……Date: / /
❑ Angina or chest pain
❑ Irregular heart beat or palpitations
❑ Congestive heart failure ("fluid on the lungs")
❑ Other (DESCRIBE)
❑ High blood pressure
❑ Heart murmur
❑ Heart valve problem
❑ Congenital heart disease (born with)
❑ High cholesterol
❑ Abnormal electrocardiogram (EKG)
❑ Heart or bypass surgery
❑ Angioplasty, stint or "balloon" procedure
❑ Pacemaker or defibrillator

5. Do you get SHORT OF BREATH while doing the following? ❑ NO ❑ YES ❑ UNSURE

❑ Climb a flight of stairs ❑ Walk up a hill ❑ Walk or run a short distance ❑ Heavy house work; exercise

6. Do you have BREATHING or LUNG problems? ❑ NO ❑ YES ❑ UNSURE

❑ Asthma
❑ Emphysema or COPD
❑ Chronic cough
❑ Other (DESCRIBE)
❑ Short of breath lying down flat
❑ Recent cold, respiratory infection, fever or chills (last 2 weeks)
❑ Recent pneumonia (last 2 months)
❑ Sleep apnea or very loud snoring
❑ Home ventilator, CPAP or BiPAP
❑ Use oxygen at home
❑ Blood clot in lungs (pulmonary embolism)

7. Do you have a LIVER, KIDNEY or PROSTATE condition? ❑ NO ❑ YES ❑ UNSURE

❑ Kidney failure
❑ Cirrhosis of the liver
❑ Hepatitis or Jaundice Type A B C
❑ Blood hemodialysis
❑ Peritoneal dialysis
❑ Other (DESCRIBE)
❑ Prostate cancer
❑ Enlarged prostate

8. Do you have DIABETES or a THYROID condition? ❑ NO ❑ YES ❑ UNSURE

❑ Diabetes ❑ Insulin treatment ❑ Hypothyroid (under active thyroid) ❑ Hyperthyroid (overactive thyroid)
❑ Other (DESCRIBE)

9. Do you have an ORAL, DIGESTIVE or WEIGHT concern? ❑ NO ❑ YES ❑ UNSURE

❑ Chipped, loose or fragile teeth
❑ Acid reflux, heartburn or hiatal hernia
❑ Other (DESCRIBE)
❑ Take diet medications
❑ Severe weight loss
❑ Obesity (overweight)

10. Do you have a BRAIN, NERVE, MUSCLE or MENTAL HEALTH condition? ❑ NO ❑ YES ❑ UNSURE

❑ Stroke or CVA/ TIA (mini-stroke)
❑ Seizures or epilepsy
❑ Anxiety (severe)
❑ Numbness or weakness
❑ Carpal tunnel
❑ Muscle disease
❑ Myasthenia gravis
❑ Multiple sclerosis
❑ Other (DESCRIBE)

11. Do you have a BLOOD DISORDER? ❑ NO ❑ YES ❑ UNSURE

❑ Anemia (low blood count) ❑ Thrombosis (blood clot) ❑ Abnormal bleeding or bruising ❑ Sickle cell disease
❑ Other (DESCRIBE)

12. Do you have ARTHRITIS, SPINE or JOINT problems? ❑ NO ❑ YES ❑ UNSURE

❑ Rheumatoid arthritis ❑ Osteoarthritis (degenerative) ❑ TMJ (jaw joint problems)
❑ Spine problems: ❑ Neck ❑ Upper back ❑ Lower back (sciatica)
❑ Other (DESCRIBE)

13. Have you had CANCER? ❑ NO ❑ YES ❑ UNSURE

❑ Type of Cancer: ❑ Chemotherapy (last 3 months) ❑ Radiation (last 3 months)

14. Do you use TOBACCO, ALCOHOL or DRUGS? θ NO θ YES θ UNSURE

❑ Cigarettes: ___packs/day for _____years ❑ Alcohol ___drinks per week ❑ Marijuana ❑ Cocaine

15. MARITAL STATUS: ❑ Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed

Patient NAME: **Today's DATE:**

16. Please list past SURGERIES and YEAR completed
❑ ________ ❑ ________ ❑ ________
❑ ________ ❑ ________ ❑ ________
❑ **If you have had surgery, have you ever received a BLOOD TRANSFUSION?** ❑ NO ❑ YES ❑ UNSURE

17. Any previous DIFFICULTIES or COMPLICATIONS with anesthesia or surgery? ❑ NO ❑ YES ❑ UNSURE

❑ Intubation (breathing tube insertion) ❑ Severe nausea or vomiting ❑ Malignant hyperthermia (you or family member)
❑ Difficulty waking up ❑ Awareness (remember surgery) ❑ Family member had anesthesia problem
❑ Other (DESCRIBE)

18. Are you HIV positive? Do you have AIDS or other INFECTIOUS DISEASES? ❑ NO ❑ YES ❑ UNSURE

❑ HIV Positive ❑ AIDS ❑ Other (DESCRIBE)

19. WOMEN: Is there a chance that you are now PREGNANT? ❑ NO ❑ YES ❑ UNSURE

Date of last Menstrual period: _____/_____/_____ Are you currently nursing? ❑ NO ❑ YES

20. Have you seen your PRIMARY PHYSICIAN or had MEDICAL TESTS in the last 3 months? ❑ NO ❑ YES ❑ UNSURE

❑ Blood tests ❑ EKG ❑ Chest X-Ray
Other:

Location where tests were done:_________ Date:______
Did your doctor request you be seen by either a Dermatologist or Ear, Nose and Throat specialist? ❑ **YES**
Name of Referring Physician

21. Have you ever had any specialized HEART TESTS? ❑ NO ❑ YES ❑ UNSURE

❑ Stress Test ❑ Echocardiogram (heart ultrasound) ❑ Heart catheterization (angiogram)

22. FAMILY HISTORY
a. Is your father living? ❑ YES ❑ UNKNOWN ❑ NO If no list cause of death:
b. Is your mother living? ❑ YES ❑ UNKNOWN ❑ NO If no list cause of death:
c. Do any of your blood relatives have a history of skin cancer? ❑ NO ❑ YES :

23. Do you take PRESCRIPTION MEDICINES? Please list--use separate sheet if necessary ❑ NO ❑ YES ❑ UNSURE
❑ ________ ❑ ________ ❑ ________

24. Do you take OTC MEDICINES or HERBAL SUPPS.? Please list--use separate sheet if necessary ❑ NO ❑ YES
❑ ________ ❑ ________ ❑ ________

25. Do you have ALLERGIES (e.g. Medicines or Latex)? ❑ NO ❑ YES ❑ UNSURE
❑ ________ ❑ ________ ❑ ________

26. Are you interested in INFORMATION on any of the following?

❑ Skin Care / Skin Care Products ❑ Sun Screen ❑ Liposuction ❑ Hair Removal ❑ Botox ❑ Foto Facial
❑ Snoring ❑ Hearing Evaluation ❑ Hearing Devices ❑ Custom Ear Plugs
Cosmetic procedures : ❑ Eyes ❑ Lips ❑ Wrinkles ❑ Skin Tightening

Patient/ Care Giver Signature : **Relationship to Patient:**

YOU MUST COMPLETE YOUR PERSONAL INFORMATION ON TOP OF PAGE TWO

Reviewing staff initials ______________________________ Date:__________