

MEDICAL HISTORY

Age _____ Height _____ Weight _____

Occupation _____ Married ___ Single ___ Divorced ___ Widow ___

Please list all medication you are currently taking including prescription, over the counter or any aspirin or ibuprofen products.

List all allergies _____

Have you ever used (circle): LSD/speed/cocaine/marijuana?

Are you a smoker? _____ How long? _____ Quit how long ago? _____

How much alcohol do you drink? _____ Caffeine? _____

Please indicate all medical conditions you now have or have had in the past.

High blood pressure _____	Bleeding tendency _____	Diabetes _____
Blood transfusions _____	Hepatitis _____	Glaucoma _____
Heart attack _____	Heart disease _____	Stroke _____
Tuberculosis _____	Ulcers _____	Seizure Disorder _____
Cancer _____	Liver Disease _____	Kidney Disease _____
Lung or Respiratory Disease _____	Anxiety _____	Depression _____

Are you currently under the care of a physician? _____

Are you currently under the care of a mental health professional? _____

Have you ever been treated with chemotherapy or radiation?

If yes, please list condition _____

List all surgeries that you have had (include any plastic surgery).

Have you or anyone in your family ever had unusual reactions to anesthesia? _____

I certify that the above is true, correct and complete. I am aware and accept that withholding information about my medical history could result in serious injury to me or harm to those involved in my care.

Patient Signature

Date

Witness Signature