MEDICAL HISTORY

Name: _____Date: _____

Age: _____ Height: _____ Weight: _____ Primary M.D: _____

Primary M.D. Phone: _____ Pharmacy: _____

Pharmacy Phone: _____

Please note any illnesses YOU have had:

__Diabetes
__Vein Trouble/Clots
__Heart Disease
__Asthma
__Stroke
__Form Keloids
__Thyroid Problem
__High Cholesterol
__Genetic Disorders
__Cancer (type) _____
__Bleeding Tendencies
__Intestinal Trouble
__Kidney Disease
__Pneumonia
__Nervous Disorders/Depression/
__Anxiety
__Headaches
__High Blood Pressure
__Arthritis

Check any illnesses that your BLOOD RELATIVES have had and **list relationship**:

__Diabetes _____
__Heart Disease_____
__Stroke _____
__High Blood Pressure_____
__Kidney Disease _____
__Arthritis _____
__Bleeding Tendencies _____
__Nervous Disorders _____
__Other _____
__Cancer (List who and what type) _____

What medications are you currently taking? List name and dose: _____

_____

_____

Do you take any herbs, vitamins, or weight loss products? Y / N

List: _____

_____

Do you take aspirin, ibuprofen, or arthritis medications? Y / N

List drug and frequency: _____

Do you have any allergies to medications? Y / N List drug and reaction: _____

_____

Do you have any environmental allergies or a LATEX ALLERGY? Y / N

List: _____

Have you ever had an adverse reaction to Novocain or Iodine? (list drug and reaction)

_____

Do you ever get cold sores? Y / N Where and how often? _____

Have you ever had any injuries or broken bones: Y / N

List: _____

List all operations you have had: (include tonsils, wisdom teeth, ear tube, etc.)

_____

Have you ever used tobacco? Y / N Do you currently use tobacco products? Y / N

If so, how long have you been using them and what do you use? _____

_____

Do you have a history of past or present drug use? Y / N

Do you consume alcohol? Y / N How much? _____

What is the reason you are seeing Dr. Carl today? _____

_____

If this is a cosmetic option, how long have you been thinking about a change? _____

_____

How did you hear about Dr. Carl? _____

_____