

Aesthetic Specialty Centre
770-393-9000 / 706-453-9863

Patient Medical History

Patient Name: _____ **Pt. #:** _____ **Date:** _____

In order to be thoroughly familiar with your individual needs, we request that you complete this form accurately.

This is part of your Medical Record and is kept absolutely confidential!

Allergies: (Latex, Lidocaine, Epinephrine, Medication) _____

Medications: _____

Are you taking any of the following? (Please circle): Aspirin, Advil, Aleve, Ibuprofen, Motrin, Nuprin, Vitamin E

Have you had any reaction to injections of a local anesthesia or general anesthesia? Yes No

Date of last physical: _____ Physician: _____

List previous surgeries you have had, dates and attending Physician: _____

Have you had any type of implants? Yes No What type? _____ When? _____

Have you had an EKG or Chest X-Ray in the past year? Yes No

Have you been on Accutane within the past 12 months? Yes No

General Health History: Have you been or are you now under treatment for any of these major medical conditions? Please circle either Yes or No.

Anemia	Yes	No	Heart Disease	Yes	No	Psychiatric Disorders	Yes	No
Arthritis	Yes	No	Hepatitis	Yes	No	Recent Weight Gain/Loss	Yes	No
Autoimmune, Lupus	Yes	No	Herpes/Cold Sores	Yes	No	Rheumatic Fever	Yes	No
Bleeding Disorders	Yes	No	High Blood Pressure	Yes	No	Psoriasis / Eczema	Yes	No
Blood Clots	Yes	No	HIV	Yes	No	Thyroid /Endocrine Disorder	Yes	No
Cancer	Yes	No	Hives	Yes	No	Skin Diseases / Cancer	Yes	No
Diabetes	Yes	No	Keloids/Scars	Yes	No	Sun Allergy	Yes	No
Eye Problems	Yes	No	Migraines	Yes	No	Neurological Disorder/Seizures	Yes	No
Hay Fever	Yes	No	Pacemaker/Defibulator	Yes	No	Kidney/Urinary Tract Diseases	Yes	No
Heart Arrhythmia/	Yes	No	Asthma / Bronchitis	Yes	No	Gastrointestinal Disease	Yes	No
Heart Murmur	Yes	No	Lung Disease/ Emphasema					

Female:

Currently Pregnant Yes No Menstrual Irregularity Yes No Birth Control Yes No

Please elaborate on or add any medical disorders and problems not mentioned above: _____

(Dentures, partials, caps, bonding, loose or chipped teeth; hiatal hernia, reflux, ulcers, rectal bleeding, sleep apnea, c-pap machine, limitation devices, mobility, visual, auditory language.)

Do you smoke? Yes No How much/often _____

Do you drink alcohol? Yes No How much/often _____

Do you drink caffeine? Yes No How much/often _____

Do you exercise regularly? Yes No How much/often _____

Recreational Drug Use/Diet Pills? Yes No How much/often _____

Family History: Have any members of your immediate family had treatment for any of the following?

Arthritis Yes No Diabetes Yes No Hay Fever Yes No

Asthma Yes No Eczema Yes No Psoriasis Yes No

Cancer Yes No Hair Loss Yes No Skin Cancer Yes No

Patient Signature

Date

Physician Signature

MA Signature

Date