

Please Describe Your Health. Please complete the following information accurately. Your responses will be held in strict confidence

Height _____ Weight _____

Have you had:

Bleeding Disorders	Y	N	High Blood Pressure	Y	N
Blood Transfusions	Y	N	Irregular Heart Beat	Y	N
Major/Severe Injuries	Y	N	Heart Attack	Y	N
Liver Disease	Y	N	Angina	Y	N
Jaundice or Hepatitis	Y	N	Cancer	Y	N
Diabetes	Y	N	G I Problems	Y	N
Stroke	Y	N	Ulcers	Y	N
Asthma	Y	N	Migraine Headaches	Y	N
Bronchitis	Y	N	Facial Nerve Damage	Y	N
Emphysema	Y	N	Dentures	Y	N
Shortness of Breath	Y	N	Dental Implants	Y	N
Varicose Veins	Y	N	Vision Problems	Y	N
Phlebitis (Blood Clots)	Y	N	Glaucoma	Y	N
Pulmonary Embolism	Y	N	HIV or A.I.D.S.	Y	N
Scleroderma/ Arthritis	Y	N	Autoimmune Diseases	Y	N

Wound Healing Problems:

Easy Bruising	Y	N	Prolonged Bleeding	Y	N
Poor Wound Healing	Y	N	Bad Scarring	Y	N

Please explain any "yes" responses: _____

Are there any other medical conditions that you have? _____

Y N Have you ever had surgery? Please explain. _____

Y N Have you ever had cosmetic surgery? Please explain. _____

What Medications do you take now?

Include dosage, frequency and purpose. (Please do not omit anything because medications used during and after surgery may interact adversely.)

Do you take any alternative medications like vitamins, herbs or homeopathic preparations ?

Y N Have you ever taken Cortisone, Prednisone, or any other steroid by injection or in tablet form?

Do you have any **ALLERGIES** to:

Antibiotics	Y	N	Prescription Medication	Y	N
Latex	Y	N	Adhesive Tape	Y	N
Skin Creams	Y	N	Other	Y	N

Please explain any "yes" responses: _____

Y N Do you smoke? How long? _____ Years. _____ Per day.

Y N Do you drink alcohol? _____ glasses of _____ per _____

Y N Do you or have you used drugs for recreational purposes within the past 2 years?
 Heroin _____ Cocaine/Crack _____ LSD/Acid _____ Other _____

Y N If necessary, may I consult with your physician?
 Name: _____
 Address: _____
 Phone: _____

Y N Have you ever received counseling or treatment for a mental condition, emotional
 problem, or depression? (Please describe and list dates.) _____

Please complete this section if you are considering *breast reduction surgery*:

Have you experienced the following:			Bra size: _____		
Neck pain	Y	N	Shoulder grooving	Y	N
Back Pain	Y	N	Rashes beneath the breasts	Y	N
Breast Pain	Y	N	History of Breast Lesions	Y	N
History of Breast Cancer	Y	N	Breast Cancer in Family	Y	N

Please explain if necessary. _____

When was your most recent mammogram: _____

Have you ever tried to relieve your pain with physical therapy, chiropractic treatment, weight loss
 or sought the care of any other physician? _____

Please complete this section if you are considering surgery of your eyes:

- Y N Do you have vision in both eyes?
- Y N Have you ever had “dry eyes”?
- Y N Do you have allergies to any eye care product? (drops, ointments, or make-up)
- Y N Is your vision corrected with Glasses? _____ Contact lenses? _____
- Y N Have you ever had surgery for your eyes or eyelids? Cataract ___ R.K. ___ Eyelid ___
- Y N Have you ever been examined by an eye doctor?
- Y N May we consult with your eye doctor?

Name: _____

Address: _____

Telephone: _____

Please complete this section if you are considering nasal surgery:

- Y N Do you have difficulty breathing through your nose?
- Y N Have you tried medications to improve your nasal breathing?
- Y N Are your nasal problems unrelated to season?
- Y N Have you broken or injured your nose?

Please explain any “yes” response. _____

We wish to protect your right for privacy:

___ Please check here if you do not wish to receive mailings from us.

___ Please check here if you do not wish E-mails from us.