General Health Questionaire

Name: _____ DOB: _____

AGE: _____ New Patient _____ Established _____

Allergies: _____

MEDICATIONS/VITAMINS/SUPPLEMENTS:

_____

_____

_____

MEDICAL CONDITIONS: (list any conditions you have been diagnosed to have)

_____

_____

_____

Have you ever had or been diagnosed with the following: (circle all that apply)

Cataracts	High Blood Pressure	Frequent Infection
Glaucoma	Kidney Stones	Cancer
Asthma	Pneumonia Thyroid Disease	Herpes Simplex/Cold Sores
Allergies	TB/LUNG Disease	HIV/AIDS
Stroke	Diabetes	Bells Palsy
Seizures/Epilepsy	Pleurisy	Body Dysmorphic Disorder
Heart Attack Ulcers	Anemia	Parkinsons Disease
Skin Cancer Hemorrhoids	Bone/Joint Disease	Myasthenia Gravis
Digestive Disorder	Jaundice/Liver Disease	Neurological Disorder
Heart Disease	Bleeding Disorders	Hyperhidrosis
Heart Murmur	Muscle Weakness	Other:
Kidney Disease	Depression	

SURGERY: Have you had any surgery to your face or neck? YES NO

List any surgery you may have had to the face or neck area:

_____

_____

Have you ever had a blood transfusion? YES NO

CURRENT WEIGHT: _____ HEIGHT: _____

Date of last physical exam: _____
(a complete physical exam is required once annually prior to any cosmetic treatment)

Do you exercise routinely? YES NO
If yes, type of exercise and how often:
_____

Do you smoke? YES NO
If yes, # per day _____ How long have you smoked? _____years

Do you drink caffeinated coffee, teas or soda regularly? YES NO

FEMALES ONLY:

Are you pregnant now or planning to become pregnant? YES NO

Are you currently breastfeeding? YES NO

_____ _____
Patient Signature **Date**

_____ _____
Nurse Signature **Date**

_____ _____
MD/NP/PA Signature **Date**