**Patient Name**

**Health Questionnaire Date of Birth**

Rate your general heath

☐Excellent ☐Good ☐Fair ☐Poor

List your medical and past surgical history including approximate dates:

List all prescription and over the counter medications and supplements you take:

Please list all drug allergies and/or problems with anesthesia

Please list any prior cosmetic or aesthetic procedures you have had (surgery, Botox, fillers, laser treatments, etc.)

Have you had any invasive or ablative procedures in the past 3 months? ☐Y ☐N

Please describe

Do you have any metal plates, implants and/or screws? ☐Y ☐N

Please describe

Do you have an internal pacemaker, defibrillator, or neural implants? ☐Y ☐N

How would you describe your consumption of alcohol?

Never 1-3 drinks/wk 5-10 drinks/wk > 10 drinks/wk

Do you smoke or chew tobacco products? ☐Y ☐N

If so, how much and number of years

Are you, or could you be, pregnant? ☐Y ☐N

Are you nursing? ☐Y ☐N

***Please turn over and complete the back of this sheet***

**Do you have or have you had any of the following diseases or problems?**

Weight loss, fatigue, fever ☐Y ☐N

Glasses/Contacts, Eye Pain, Double Vision/Cataract ☐Y ☐N

Difficulty hearing, ringing in ears, Vertigo, sinus troubles ☐Y ☐N

Heart murmur, chest pain, palpitations, dizziness, fainting spells,

shortness of breath, difficulty lying flat, swelling ankles ☐Y ☐N

Loss of hair, heat/cold intolerance, thyroid problems, diabetes ☐Y ☐N

Cough, coughing blood, wheezing, chills, asthma, COPD ☐Y ☐N

Heartburn/reflux, nausea/vomiting, constipation, diarrhea, change in BM’s

Jaundice, abdominal pain, black or bloody stool, hepatitis ☐Y ☐N

Urinary frequency/burning, bladder leakage, blood in urine, kidney stones,

Erectile dysfunction (M), painful intercourse (F), sexually transmitted

diseases (including herpes) ☐Y ☐N

Hives, eczema, hay fever, seasonal allergies ☐Y ☐N

Anxiety, depression, mood swings, difficulty sleeping ☐Y ☐N

Easing bruising, bleeding gums, enlarged glands, blood disorders, history

of blood clots, or pulmonary emboli ☐Y ☐N

Joint pain, stiffness, muscle pain, back pain ☐Y ☐N

Rash/sores, lesions, itching/burning skin, cold sores, lip blisters, recent

use of Accutane, scarring or keloid formation ☐Y ☐N

Loss of strength, memory loss, numbness, balance problems, history of

stroke or seizure, tremors, unsteady gait, double vision, headaches ☐Y ☐N

History of cancer ☐Y ☐N

Please explain any items where you checked yes:

**I, MYSELF, HAVE FILLED OUT THIS HEALTH QUESTIONNAIRE COMPLETELY AND I HAVE DISCLOSED ALL OF MY MEDICAL PROBLEMS.**

**Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**