

Patient Name \_\_\_\_\_ MR# \_\_\_\_\_

Date \_\_\_\_\_

# HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

## PERSONAL INFORMATION

		◆ M ◆ F	DOB (mm/dd/yyyy)	
Street Address			Home Phone	
City, State, Zip			Work Phone	
SS#		Occupation/Employer		
Driver's License #		Race/Ethnicity		
Marital Status	◆ Single      ◆ Partnered      ◆ Married      ◆ Separated      ◆ Divorced      ◆ Widowed			
Spouse/Partner Name			DOB (mm/dd/yyyy)	
Phone		Occupation/Employer		
Parent/Guardian's Name (If under 18)				
Emergency Contact (Other than Spouse)				Relationship
Address				Phone

## INSURANCE & BILLING INFORMATION

Billing Name (If other than Patient)			Relationship to Patient	
Billing Address			Phone	
1	Insurance Co	Address		
	Name of Insured	Relationship	Group #	
	Effective Date	Benefit Code	ID #	
2	Insurance Co	Address		
	Name of Insured	Relationship	Group #	
	Effective Date	Benefit Code	ID #	
Medicare ID#			Medicaid ID#	

Other Coverage

## GENERAL HEALTH

What are you here for today?

Have you consulted any other doctor about this?    ◆ Yes    ◆ No    Optional: Please list his/her name(s)

Describe your general health    ◆ Good    ◆ Fair    ◆ Poor    Explain if not good:

Date of last physical exam      Referred by      Office phone

## PERSONAL HEALTH HISTORY

Childhood illness    ◆ Measles      ◆ Mumps      ◆ Rubella      ◆ Chickenpox      ◆ Polio      ◆ Rheumatic Fever

Immunizations    ◆ Tetanus      ◆ Hepatitis      ◆ Influenza      ◆ Pneumonia      ◆ Chickenpox      ◆ Measles, Mumps, Rubella

## Surgeries, Hospitalizations and Complications

Year and Hospital	Reason	Complications or After-Effects

Have you ever had a blood transfusion?      ◆ Yes    ◆ No

Patient Name _____	MR# _____
	Date _____

**Please list ALL your prescribed drugs and over-the-counter drugs.** Include Birth Control, Diuretics, Heart and Blood Pressure medication, Hormone Therapy, Nasal Sprays, Blood Thinners, Aspirin, Rub-On-Creams, Weight Loss medications, Laxatives, Vitamins, Inhalers, etc.

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

**Allergies to medications**

Name of Drug	Reaction You Had

**MEDICAL HISTORY**

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

◆ Skin	◆ Throat	◆ Intestinal	Recent changes in:
◆ Head/Neck	◆ Lungs	◆ Bladder	◆ Weight
◆ Ears	◆ Chest/Heart	◆ Bowel	◆ Energy level
◆ Nose	◆ Back	◆ Circulation	◆ Ability to sleep

◆ Other pain/discomfort:

Explain:

**DIAGNOSIS HISTORY**

Mark "C" for Current Problems. Check and indicate age when you had any of the following symptoms or diseases.

◆ Dizzy spells	◆ Shortness of breath:	◆ Gallbladder trouble	◆ Back pain - <i>recurrent</i>
◆ Fainting spells	◆ on exertion   ◆ lying flat	◆ Jaundice/Hepatitis	◆ Bone fracture/joint injury
◆ Failing vision	◆ High blood pressure	◆ Sexually transmitted diseases	◆ Osteoporosis
◆ Eye Pain	◆ Heart trouble	◆ Cancer	◆ Tuberculosis
◆ Double or blurred vision	◆ Leg pain – when walking	◆ Chronic fatigue	◆ Herpes
◆ Hayfever/Allergies	◆ Varicose veins/Plebitis	◆ Diabetes	◆ AIDS/HIV
◆ Pneumonia	◆ Difficulty swallow	◆ Thyroid disease	◆ Acupuncture/tattoos
◆ Bronchitis/Chronic cough	◆ Heartburn	◆ Numbness/tingling sensations	◆ Hair loss:
◆ Asthma/Wheezing	◆ Peptic ulcer	◆ Headaches – frequent	◆ progressive   ◆ recent
◆ Chest pain	◆ Abdominal pain	◆ Arthritis/Rheumatism	◆ Other

Explain:

**WOMEN ONLY**

Date of last menstruation:

Heavy periods, irregularity, spotting, pain, or discharge? ◆ Yes   ◆ No

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_

Are you pregnant or breastfeeding? ◆ Yes   ◆ No

Any urinary tract, bladder, or kidney infections within the last year? ◆ Yes   ◆ No

Experienced any recent breast tenderness, lumps, or nipple discharge? ◆ Yes   ◆ No

Date of last mammogram?	Was it Normal?	◆ Yes	◆ No
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Patient Name \_\_\_\_\_ MR# \_\_\_\_\_

Date \_\_\_\_\_

**FAMILY HEALTH HISTORY**

If any blood relative has suffered any of the following – please circle the number, then list the number & indicate which relative.

1. Epilepsy	8. Asthma	15. Hypertension	
2. Migraine	9. Anemia	16. High cholesterol	
3. Mental illness	10. Bleeds easily	17. Alcoholism	
4. Glaucoma	11. Osteoporosis	18. Hepatitis	
5. Diabetes	12. Arthritis	19. Cancer	
6. Thyroid	13. Heart disease	20. Other	
7. Hayfever	14. Stroke		

**MENTAL HEALTH**

Is stress a major problem for you?	◆ Yes	◆ No
Do you feel depressed?	◆ Yes	◆ No
Do you panic when stressed?	◆ Yes	◆ No
Do you have problems with eating or your appetite?	◆ Yes	◆ No
Do you cry frequently?	◆ Yes	◆ No
Have you ever attempted suicide?	◆ Yes	◆ No
Have you ever seriously thought about hurting yourself?	◆ Yes	◆ No
Do you have trouble sleeping?	◆ Yes	◆ No
Have you ever been to a counselor?	◆ Yes	◆ No

**HEALTH HABITS AND PERSONAL SAFETY**

All questions contained in this questionnaire are optional and will be kept strictly confidential

<b>Exercise</b>	◆ Sedentary (No exercise)				
	◆ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	◆ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 minutes)				
	◆ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
<b>Diet</b>	<b>Are you dieting?</b>		◆ Yes	◆ No	
	If yes, are you on a physician prescribed medical diet?		◆ Yes	◆ No	
	<b># of meals you eat in an average day?</b>				
	<b>Rank salt intake</b>	◆ Hi	◆ Medium	◆ Low	
	<b>Rank fat intake</b>	◆ Hi	◆ Medium	◆ Low	
<b>Rank carbohydrate intake</b>	◆ Hi	◆ Medium	◆ Low		
<b>Caffeine</b>	◆ None	◆ Coffee # of cups/day	◆ Tea # of cups/day	◆ Soda # of cans/day	
<b>Alcohol</b>	<b>Do you drink alcohol?</b>	◆ Yes	◆ No	How many drinks per week?	
<b>Tobacco</b>	<b>Do you use tobacco?</b>			◆ Yes	◆ No
	<b>Amount of tobacco each day</b>		<b># of years</b>	<b>Year quit?</b>	
<b>Drugs</b>	<b>Do you currently use recreational or street drugs?</b>			◆ Yes	◆ No
	<b>Have you ever given yourself street drugs with a needle?</b>			◆ Yes	◆ No
<b>Sex</b>	<b>Are you sexually active?</b>			◆ Yes	◆ No
	If yes, are you trying for a pregnancy?			◆ Yes	◆ No
	If yes, do you practice safe sex?			◆ Yes	◆ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse.			◆ Yes	◆ No

Patient Name \_\_\_\_\_ MR# \_\_\_\_\_

Date \_\_\_\_\_

	<b>Do you have reason to believe that you may be at risk for this illness?</b>		
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Patient Name _____	MR# _____
	Date _____

**COSMETIC HISTORY**

<b>EYE Color</b>	◆ Blue	◆ Green	◆ Hazel	◆ Grey	◆ Light Brown	◆ Dark Brown		
<b>HAIR Color</b>	◆ Blonde	◆ Red	◆ Light Brown	◆ Medium Brown	◆ Dark Brown	◆ Black	◆ Grey/Silver	◆ White
<b>SKIN Tone</b>	◆ Pale/White	◆ Light	◆ Reddish/Freckles	◆ Light Olive	◆ Medium Olive	◆ Dark Olive	◆ Brown	◆ Black
<b>Check all SKIN TYPES that apply to your skin:</b>	◆ Normal	◆ Oily	◆ Dry	◆ T-Zone, Combination	◆ Freckled	◆ Occasional Breakouts		
	◆ Uneven, Blotchy	◆ Mature	◆ Wrinkled	◆ Sagging	◆ Firm	◆ Sun Damaged		
	◆ Large Pores	◆ Small Pores	◆ Acne	◆ Milia	◆ Comedones	◆ Scarred		
	◆ Cystic	◆ Melasma	◆ Florid	◆ Rosacea	◆ Asphyxiated	◆ Sallow		
	◆ Perfumed-Stained		◆ Hypopigmented		◆ Post-Inflammatory Hyperpigmented			

<b>Do you consider your skin</b>	◆ Sensitive	◆ Resilient
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<b>Do you consider your skin</b>	◆ Fair (Burns easy in sun)	◆ Moderate (Burns occasionally in sun)	◆ Dark (Do not burn)
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<b>Do you go to tanning booths? (If so, decline treatment)</b>	◆ Yes	◆ No
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<b>Do you get facial waxing, electrolysis, or use depilatories?</b>	◆ Yes	◆ No
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<b>Have you had collagen or other filler injections recently?</b>	◆ Yes	◆ No
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If yes, please explain:

<b>Have you ever had a peel?</b>	◆ Yes	◆ No
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If yes, please explain and describe your reaction:

<b>Have you ever had BOTOX treatments?</b>	◆ Yes	◆ No
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If yes, please explain and describe your reaction:

**Are you using any of the following:**

<b>Retin A?</b>	◆ Yes	◆ No	How frequently?	Where do you apply it?
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<b>Accutane?</b>	◆ Yes	◆ No	
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<b>Hormones/other medication?</b>	◆ Yes	◆ No	If yes, which one(s)?
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<b>Glycolic/AHA home care</b>	◆ Yes	◆ No	If yes, which one(s)?
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**How does your skin react to them?**

<b>Have you had a bad reaction to any</b>	◆ Yes	◆ No	Describe:
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<b>Check any to which you are</b>	◆ Milk	◆ Apples	◆ Citrus	◆ Grapes	◆ Aloe Vera	◆ Aspirin	◆ Hydroquinone	◆ Eggs
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<b>Any blood in your urine or stool?</b>	◆ Yes	◆ No
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<b>Do you ever get nose bleeds?</b>	◆ Yes	◆ No
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<b>Do you bruise easily?</b>	◆ Yes	◆ No
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<b>Do you have a history of Oral Herpes (such as cold sores)?</b>	◆ Yes	◆ No
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<b>Any vascular disease (such as Scleroderma, Raynaud's, Burger's Disease)?</b>	◆ Yes	◆ No
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**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize Dr. \_\_\_\_\_ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

**CONSENT TO RELEASE PHOTOGRAPHS**

I hereby authorize Dr. \_\_\_\_\_ to release of all photographs that may be necessary for use in medical journals, internet use, marketing, plastic surgery conferences, and presentations.

**MEDICARE – MEDICAID**

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

**ASSIGNMENT OF INSURANCE PATIENTS**

I hereby authorize direct payment of surgical/medical benefits to Dr. \_\_\_\_\_ for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize Dr. \_\_\_\_\_ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

\* A photocopy of these assignments shall be as valid as the original \*

<b>Patient Name (please print)</b>	<b>Date</b>
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Patient Name \_\_\_\_\_ MR# \_\_\_\_\_  
Date \_\_\_\_\_

**Parent/Guardian (please print)**

**Signature**

Patient Name \_\_\_\_\_ MR# \_\_\_\_\_

Date \_\_\_\_\_

**PHYSICIAN NOTES**

Large empty rectangular area for physician notes.

**PHYSICAL EXAM**

Height	Weight	Recent Wt Change +/-	Blood Pressure
Large empty area for recording physical exam data.			

**A/P**

Large empty rectangular area for A/P notes.

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_