

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Numbers: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of plastic procedure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes, I am currently taking prescription drugs. Please list below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes, I am currently taking supplements and/or vitamins. Please list below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes, I have an infectious disease. Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes, I have allergies. Please indicate:

Foods – Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications – Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bites/Stings – Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seasonal – Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Animals – Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other – Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Health History** (Please check if any of the following apply to you)

|  |  |  |
| --- | --- | --- |
| AIDS | Diabetes | Hepatitis |
| Alcoholism | Emphysema | High Blood Pressure |
| Asthma | Epilepsy | Multiple Sclerosis |
| Allergies | Endocrine Disorder | Thyroid Disease |
| Arteriosclerosis | Gout | Childhood Fevers |
| Birth Trauma (yours) | Heart Disease | Childhood Illnesses |

Major Surgeries (please list all with approx. dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Significant Trauma (auto accidents, falls, etc. Please list with approx. date of injury): \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **Current Symptoms** (Please check if any of the following apply)  |
| Headaches | Urination Difficulties | Constipation/Diarrhea |
| Vision Problems | Infertility | Skin Disorders |
| Jaw/Teeth Pain | Impotence | PMS |
| Ear Pain | Muscular Pain | Menstrual Disorders |
| Sinus Pain/Problems | Joint Dysfunction/Pain | Menopausal Problems |
| Throat Pain/Problems | High/Low Blood Pressure | Anxiety |
| Breathing Difficulties | Depression | Chest Pain |
| Chills | Overly Emotional | Excess Thirst |
| Fever | Fatigue | Lack of Thirst |
| Indigestion | Dizziness | Spontaneous Sweating |
| Insomnia | Weight Loss | Night Sweating |
| Nervousness | Weight Gain | Lack of Sweating |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any additional information about yourself** -

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Typical Daily Diet and Exercise**

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**Please check if you experience any of the following on a regular basis:**

**Head, Eyes, Ears, Nose, Throat**

|  |  |  |
| --- | --- | --- |
| Glasses | Ear Ringing | Teeth Removed |
| Night Blindness | Hearing Loss | Numerous Cavities |
| Eye Strain | Earaches | Teeth Grinding |
| Eye Pain | Ringing in Ears | TMJ |
| Red Eyes | Headaches | Gum Problems |
| Itchy Eyes | Migraines | Lip Sores |
| Spots in Eyes | Concussions | Mouth Sores |
| Spots in Visions | Throat Drainage | Excessive Saliva |
| Blurred Vision | Throat Tickle | Facial Pain |
| Glaucoma | Sore Throat | Facial Numbness |
| Cataracts | Swollen Glands | Sinus Problem |
| Nosebleeds | Lump in Throat | Sinus Drainage |
| Heaviness of Head**Respiratory**  | Enlarged Thyroid |  |
| Difficulty Breathing | Tight Chest | Pleurisy |
| Shortness of Breath | Asthma | Phlegm/Congestion |
| Chronic Cough | Wheezing | Rattling Sound with Breath |
| Acute Cough **Cardiovascular**  | Pneumonia | Can’t Sleep Lying Down |
| Hypertension (High BloodPressure) | Blood Clots | Hypotension (Low BloodPressure) |
| Chest Pain | Rapid Heart Rate | Fainting |
| Palpitations | Edema (Swelling) | Irregular Heart Rate |
| Slow Heart Rate**Gastrointestinal**  | Pacemaker |  |
| Nausea | Diarrhea | Dark Colored Stool |
| Vomiting | Constipation | Light Colored Stool |
| Acid Regurgitation/Reflux | Use Laxatives | Mucus in Stools |
| Gas/Flatulence | Use Antacids | Blood in Stools |
| Hemorrhoids | Hiccups | Use Fiber |
| Rectal Pain/Itching | Bloating | Use Digestive Enzymes |
| Fissures | Bad Breath | Intestinal Pain |
| Bowel Movement 1X/Day | Vomiting Blood | Poor Appetite |
| Bowel Movement Greater than 1X/Day**Genito-Urinary**  | Bowel Movement Less than1X/Day |  |
| Pain with Urination | Bed Wetting | Impotence |
| Frequent Urination | Wake to Urinate | Premature Ejaculation |
| Urgent Urination | Frequent UTIs | Nocturnal Emissions |
| Incomplete Urination | STD | Blood in Urine |
| Increased LibidoKidney Stones | Decreased Libido | Dribbling |

**Musculo-Skeletal**

|  |  |  |
| --- | --- | --- |
| Muscle Weakness | Chronic Pain | Limited Range of Motion |
| Muscle Cramps | Acute Pain (short-term pain)  | Arthritis |
| Muscle Spasms | Injuries | General Aches |
| Joint Pain | Muscle Atrophy |  |
| Joint Instability**Neurological**  | Falls |  |
| Fainting/Syncope | Dizziness | Vertigo |
| Drowsiness | Loss of Balance | Poor Memory |
| Tremor | Convulsions | Paralysis |
| Stroke/CVA/TIA **Neurophysiological**  | Seizures | Numbness |
| Depression | Worry Easily – Anxious | Abuse Survivor |
| Irritable | Unresolved Grief | Receiving Counseling |
| Easily Stressed | Frightened Easily | Received Counseling |
| Easily Frustrated**Skin and Hair**  | Numbness | Poor Memory |
| Rashes | Psoriasis | Hair Loss |
| Hives | Acne | Hair Changes |
| Ulcerations | Itching | Hair Breaking |
| Eczema | Dandruff | Thin Slow Growing Nails |
| Fungal Infection**Vitality and Immune System**  | Premature Graying | Skin Changes |
| Frequent Colds | Chronic Mental Cloudiness  | Slow Wound Healing |
| Frequent Flu | Low Energy | Tender/Achy All Over |
| Less Ability to Adapt**Gynecology** N/A  | Lethargic |  |
| Pregnant | Decreased Libido | Hysterectomy |
| Could be Pregnant | Increased Libido | Excess Vaginal Discharge |
| Pregnancies #\_\_\_\_\_\_ | PMS | Vaginal Odor |
| Miscarries #\_\_\_\_\_\_\_ | Pain Before Menstruation | Vaginal Sores |
| Abortions #\_\_\_\_\_\_\_ | Pain During Menstruation | Vaginal Dryness |
| Pre-Mature Births #\_\_\_ | Pain After Menstruation | Vaginal Itching |
| Use Birth Control Pills | Bone Density Changes | Vaginal Pain |
| Use Birth Control, Other | Fibrocystic Breasts | Spotting Between Cycles |
| Use No Contraceptives | Breast Lumps | Blood Clots |
| Use HRT | Breast Tenderness | Heavy Bleeding – Weeks |
| Menopausal | Mastectomy | Regular Self Breast Exams |
| Peri-Menopausal Age of first period \_\_\_\_\_\_\_\_\_\_Age of Menopause\_\_\_\_\_\_\_\_\_ | Lumpectomy |  |
| Date of Last PAP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Mammogram \_\_\_\_\_\_\_\_\_\_\_\_**Current Menses:**  |

Date of last period \_\_\_\_\_\_\_\_\_\_ Days between periods \_\_\_\_\_\_\_ Days of Bleeding \_\_\_\_\_\_