**MEDICAL HISTORY**

In order to provide the best care and optimal results, we need to know more about you. Please check any that apply and don’t omit any information as it may hinder the care we are able to provide.

**Do you Suffer From Any Of The Following?:(please check any that apply)**

\_\_\_Skin or Other Cancer ?

\_\_\_Seasonal Allergies/Hay Fever?

\_\_\_ Asthma?

\_\_\_Difficulties with Bleeding/Clots?

\_\_\_Difficulties with scarring/keloids?

\_\_\_HIV/AIDS/Hepatitis C?

\_\_\_High Blood Pressure

\_\_\_Heart Disease

\_\_\_Liver Disease

\_\_\_Lung Disease

\_\_\_Bleeding Disorder

\_\_\_Prior Stroke

\_\_\_Glaucoma

\_\_\_Diabetes

\_\_\_Thyroid Problem

\_\_\_Prostate Enlargement

\_\_\_Problem With Anesthesia

\_\_\_Bowel Problems

\_\_\_Kidney/Bladder Problems

\_\_\_Arthritis

**Do You Have Or Are You Currently: (please check any that apply)**

\_\_\_Do you have a pacemaker?

\_\_\_Pregnant/Planning to be?

\_\_\_Are you breastfeeding?

\_\_\_Do you wear contact lenses?

\_\_\_Alcohol Use?

\_\_\_Recreational Drugs?

\_\_\_Antibiotics in the last 2 wks?

Nicotine Use? Y/ N

How Many Years?\_\_\_\_

#Years Since Quit? \_ \_

**Please list any known allergies:**

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**Please list any other medical conditions for which you have/are currently receiving treatments:**

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**Please list all medications & dosage that you are currently taking including non-prescription medication:**

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**Past surgeries or hospitalizations: Date: Doctor:**

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**Please list any illnesses found in blood relatives.**

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\*\*Surgery can not be scheduled or performed if you are using any kind of Nicotine products such as: cigarettes, vape pens, nicotine gum, chewing tobacco, nicotine patches, cigars, e-cigarettes, smokeless tobacco.

\*\*A nicotine test will be performed the morning of surgery.