pfrankMD™

Health History Questionnaire

Please be aware that all personal information is protected under federal privacy laws

Name: _____ Age: _____ Ht: _____ Wt: _____

Address: _____ _____

Street:_____ State: _____ Zip Code_____

Home Phone: ( )_____ **Mobile**: ( )_____

Occupation: _____ **Email:** _____

Date of Birth: _____ Pharmacy Name and Phone: _____

In Case of Emergency, Please Contact: _____ Phone: ( )_____

Are you in good health? _____ Are you under the care of a physician? Y N
If so, whom? _____

Please list any drug allergies: _____

Please list **all** medications you are currently taking (Include any over the counter medications):_____
_____

Please list any current or past medical illnesses: _____
_____

Please list all hospitalizations, injuries or accidents with dates: _____
_____

Please list any surgeries (including cosmetic) with dates: _____
_____

Please list any other fact of a medical or other nature that you feel you should make known before your visit: _____

_____

If Female, are you pregnant or planning a pregnancy? Y N
Do you have any problems associated with your menstrual period? Y N
Are you nursing? Y N Are you taking birth control pills? Y N

Any significant heredity disorders (Excessive Bleeding):_____
Do you smoke? Y N If so, how much _____
Do you drink alcohol? ( ) None ( ) Occasionally ( ) Moderately ( ) Excessively
Do you wear contacts? Y N Do you wear removable dental appliances? Y N

Please answer the following questions
Do you have a history of chronic skin condition?……..Y N
Do you have a personal or family history of Cancer?…….. .Y N
Do you have herpes/cold sore breakouts?…… .Y N
Do you have asthma or any chronic lung or bronchial condition?…….Y N
Do you have a history of cardiovascular disease?……..Y N
Do you have damaged or artificial heart valves, including murmurs and prolapse?…..Y N
Do you have high blood pressure or cholesterol?……...Y N
Do you have abdominal problems including colitis and peptic ulcers?…….....Y N
Do you have a history of hepatitis?……Y N
Any trouble with your kidneys, bladder or reproductive system?……...Y N
Any bone joint or muscular trouble?……...Y N
Do you have any of the following: diabetes, epilepsy, or high blood pressure?…….Y N
Are you HIV positive?……Y N
Have you ever been under the care of a psychiatrist or psychologist?……Y N
Do you bleed or bruise easily?……Y N
Have you ever had a blood transfusion?……..Y N
Have you ever had excessive bleeding following surgery or dental work?……Y N
(For Women) Do your periods last longer than 4 or 5 days?……...Y N
Have you ever had a poor scarring or keloid formation following an operation or vaccination?……Y N
Did you ever have a bad recovery following a prior surgery?……Y N
Have you ever been dissatisfied with the treatment you received from a doctor?…… Y N
If yes, please explain:_____

Reason for visit:_____

Referred by: ☐ Friend/Dr/Other_____ ☐ Article/TV ☐ Internet

I certify that I have read and understand the questions above. I acknowledge that the questions about the above have been answered with full disclosure of my medical history. I will not hold my surgeon, or any of his/her staff responsible for any errors or omissions that I have made in completing this Health History Questionnaire. **I am aware that there will be an office fee for all cosmetic and medical consultations unless otherwise specified by our staff prior to the visit. Please be advised we do not accept personal checks on the initial visit.**

Signature:_____ Date:_____