SPLIT ROCK AESTHETIC INSTITUTE

PATIENT MEDICAL HISTORY

Name: _____ **Date of Birth:** _____ **Age:** _____

Please answer the following questions. Your answers are for our medical records only and are confidential.

1. Please list any hospitalizations, operations, significant illnesses, diagnoses, or psychiatric treatment with approximate dates:

_____

_____

_____

2. Please list any **medications, drugs, or pills** you are currently taking; include prescription medications, vitamins, enzymes, herbal or homeopathic remedies, etc. Include any prescription or over the counter **skin creams, lotions**, etc. Please use reverse side if necessary.

_____

_____

_____

3. Do you have any **allergies to medication?** **Yes / No (please circle)** If yes, describe:

_____

_____

4. Do you have an **allergy to peanuts, soy, eggs or latex?** **Yes / No (please circle)**

5. Have you ever had a **fever blister, cold sore, herpes outbreak?** **Yes / No (please circle)** If yes, how often? Most recent occurrence?

_____

6. Do you **smoke or use any nicotine** products? **Yes / No (please circle)** If yes, how much/day_____

7. Do you drink **alcohol?** **Yes / No (please circle)** How often? _____

_____

8. Has there been any change in your general health within the past year? **Yes / No (please circle)** If yes, please describe:

_____

_____

9. Please provide **Primary Care Physician name and telephone number:**

_____

Patient signature: _____ ***Date:*** _____