Ohio Valley Surgical Arts
Cosmetic + Laser Center

PATIENT HEALTH HISTORY

Name: _____ Date of Birth:_____ Age: _____ Sex: M ____ F ____

Address :_____

City/State/Zip: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____
Please circle preferred contact phone # Best time to call: _____

E-mail address: _____

Please list all medications including prescription, over the counter drugs, vitamins, supplements:

_____ _____ _____

_____ _____ _____

_____ _____ _____

List all drug and/or latex **Allergies**:_____

Occupation: _____

Are you a smoker? ____ Yes ____ No Ex-smoker? ____ Yes ____ No

How much are (were) you smoking? _____ How long? _____ Quit how long ago? _____

How much alcohol do you drink? _____ Caffeine? _____

Are you currently using recreational drugs? _____ Yes ____ No

Females: Pregnant or trying to conceive? ____Yes ____ No Breastfeeding ____Yes ____ No

Are you currently being treated for any medical condition? ___Y ___N
Please explain _____

Have you used Accutane within the last 6 months? ___Y ___N

Do you have a history of herpes simplex (cold sores)? ___Y ___N
Last outbreak: _____

Are you currently using Retin A or glycolic acid products? ___Y ___N

What skin care products are you currently using?
_____
_____

Do you have any permanent cosmetics or tattoos in the area to be treated? ___Y ___N
Where? _____

Do you have a pacemaker, metal, or any implants? ___Y ___N
Where? _____

Have you had a heart valve replacement or vascular graft? ___Y ___N
When? _____

Have you used a tanning bed or self tanning products within the last month? ___Y ___N
When? _____

Have you been exposed to the sun/UV rays within the last month? ___Y ___N
___By the pool ___Yard work ___Outdoor exercise ___Tanning booth

Are you planning a vacation in the sun? ___Y ___N

Past surgeries and dates if known:
_____

_____

Have you ever had any adverse reactions to anesthetic? ___Y ____N

Medical History – Please check all that apply:

	Abdominal pain or Heart Burn		Hepatitis C		Stroke
	Acne		High Blood Pressure		Swelling of feet, ankles or hands
	Anemia		HIV		Thyroid problems
	Anesthesia problems		Hoarseness		Tuberculosis
	Asthma		Incontinence		Varicose veins
	Bells Palsy/Facial Paralysis		Insomnia		Very Dry, flaking skin
	Bleeding gums or mouth sores		Intestinal ulcers or bleeding		
	Bleeding or Bruising Tendency		Irregular Heart Beat		Other:
	Blood in urine		Joint pain/stiffness/swelling		
	Blood Transfusion		Kidney stones		
	Blurred or double vision		Kidney trouble		
	Bronchitis		Liver disease		
	Burning or painful urination		Loss of appetite		
	Cancer		Low blood pressure		
	Change in hair or nails		Low blood sugar		
	Change in skin color		Lung Disease		
	Chest Pain		Lupus		
	Chronic or frequent coughs		Malignant Hyperthermia		
	Convulsions or seizures		Memory loss or confusion		
	Depression		Mental Illness		
	Diabetes		Moles that are irritated or bleeding		
	Difficulty swallowing		Muscle pains or cramps		
	Dizziness		Nasal blockage		
	Drug or alcohol addiction		Nervousness		
	Emphysema		Nose bleeds		
	Endocrine disorders		Palpitations		
	Epilepsy		Peptic Ulcer		
	Excessive thirst or urination		Rash or itching		
	Eye disease or injury		Recent Weight Change		
	Fainting spells		Rheumatic fever		
	Fatigue		Rheumatoid arthritis		
	Fever		Scar problems		
	Frequent diarrhea, nausea or vomiting		Scleroderma		
	Gallbladder trouble		Shortness of breath		
	Glaucoma		Sinus problems		
	Healing problems		Sleep apnea		
	Hearing loss or ringing in ears		Slow to heal after cuts		
	Heart Attack		Snoring		
	Heart Burn/Reflux		Sores that have not healed		
	Heart Disease		Spitting up blood		
	Hepatitis B		Stomach ulcers		

Family History-Please check all that apply and list relationship:

	Condition	***Relationship***		***Condition***	***Relationship***
	Asthma			Diabetes	
	Pneumonia			Cancer	
	Hepatitis			Reaction to Anesthetic	
	Bleeding Disorders			Other:	
	Heart Disease				

I agree that the answers listed above are true and correct.

Signature of Patient: _____ Date: _____

Signature of Nurse/MA: _____ Date: _____

Signature of Doctor: _____ Date: _____