ZELKO

AESTHETICS

HEALTH HISTORY FORM

Name: ______________________________ DOB: ______________

Address: ______________________________

City: ____________________ State: __________ Zip: __________

Email: ____________________Home Phone: __________Cell: __________

How did you hear about us? ______________________________

Emergency Contact: ____________________ Phone: ____________________

Physician: ____________________ Phone: ____________________

Preferred Pharmacy: ____________________ Phone: ____________________

Your current medical condition: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Weight: __________ Height: __________ Date of last physical: ______________

Do you have sensitivity to **latex**? ☐ Yes ☐ No

Have you ever had a bad reaction to **local anesthetic**? ☐ Yes ☐ No Describe: ______________

Do you have any allergies? ______________________________

List prescription and non-prescription medications you are taking, including any drugs taken in the last 6 months (steroids, cocaine, herbal remedies or vitamins):

____________________ Dose: __________ Frequency: __________

____________________ Dose: __________ Frequency: __________

____________________ Dose: __________ Frequency: __________

____________________ Dose: __________ Frequency: __________

Have you had any surgical operations within the last 5 years? (Indicate date)

☐ Cholecystectomy ☐ Appendectomy ☐ Hysterectomy ☐ C-Section ☐GI Procedure

☐ Scopes ☐ Other: ______________________________

MEDICAL HISTORY - Do you have any of the following medical conditions? Please check all that apply:

☐ Lung disorder/asthma ☐ Heart trouble/renal disease ☐ Stroke

☐ Disorder of digestive tract ☐ Disease of the kidney ☐ Arthritis

☐ Malaria ☐ High cholesterol ☐ Ulcer

☐ HIV or AIDS ☐ High blood pressure ☐ Murmur

☐ Nervous disorder ☐ Cancer ____________________ ☐ Diabetes

☐ Hepatitis or jaundice ☐ Excessive Bleeding ☐ Thyroid problem

☐ Circulation problem ☐ Seizure disorder ☐ Keloids

☐ Immunosuppression ☐ Coagulopathies ☐ Hernia

☐ Other: ____

☐ Disease or disorder of the blood? Please describe: ______________________________

☐ Life-threatening conditions? Please describe: ______________________________

☐ Contagious diseases or disorders? Please describe: ______________________________

FAMILY HISTORY - Please indicate the current status of your immediate family members (parent, sibling, grandparents, aunt/uncle with any of the following conditions:

☐ Alcoholism ______________________ ☐ High cholesterol ______________________

☐ Cancer ____________ Type: ____________ ☐ High blood pressure______________________

☐ Heart disease ______________________ ☐ Stroke______________________

☐ Depression/suicide______________________ ☐ Bleeding/clotting disorder______________________

☐ Genetic disorders______________________ ☐Asthma/COPD______________________

☐ Diabetes______________________ ☐ Other______________________

WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No ☐ Maybe Nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No Hormone medication? ☐ Yes ☐ No

List hormone replacement therapy: ____

SOCIAL HISTORY:

Are you a current smoker? ☐ Yes ☐ No ☐ Never Packs/day: ____________

Number of years: ____________ Quit date: _______________ Are you interested in quitting? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No Number of drinks/week: ______________

Do you use recreational drugs? ☐ Yes ☐ No Caffeine Intake/Coffee/tea/soda __________cups/day

OTHER CONCERNS:

Are you satisfied with your weight? ☐ Yes ☐ No

How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Do you exercise regularly? ☐ Yes ☐ No What kind of exercise:____

Minutes/day: ________________________________ How often: ____

Signature: ____ Date: ___________________________

CONSULTATION NOTES: