PATIENT PROFILE & HEALTH HISTORY FORM

Information contained here will be treated in a confidential manner and not released without your authorization. Please take the time to answer all appropriate questions to the best of your knowledge, as this information is important to us in decisions regarding your care.

Name:_____ Date of Birth:_____ Age:_____

Height:_____ Weight:_____ Ideal Weight:_____ Sex:_____ Marital Status:_____

SS#:_____Referred By:_____ Personal Physician:_____

Home Address: _____City:_____State: _____ Zip: _____

Email Address: _____ Occupation: _____

Home Telephone:_____ Cell Telephone:_____ Work Phone:_____

Please list all names of medications taken during the past 6 months: _____

Please list any vitamins?:_____ Topical medications (Retin-A, Accutane, etc.)?:_____

Please list any allergies or sensitivities:_____

Please list all previous operations, dates and any complications:_____

Please list any health problems:_____

Family health problems:_____

Date/Result of last mammogram:_____ Date of last menstrual period:_____ Are you pregnant?_____

Do you smoke?:_____ Avg # of packs per day:_____ # of years:_____ Date quit:_____

Do you drink beer or alcohol?:_____ How much?:_____ How many caffinated beverages per day?:_____

Please let us know of any other concerns you may have that will make your visit with us an enjoyable one:_____

_____

Signature:_____ **Date:**_____