MEDICAL & PERSONAL HISTORY

Name: _____ **Date:** _____

Social Security #: _____ **Birth Date** (mm/dd/yyyy)**:** _____/_____/_____

Address: _____ City: _____ St: _____ Zip:_____

Phone: (Home) _____ (Work) _____ (Cell) _____

Email address: _____

EMERGENCY CONTACT _____ _PHONE #_____

PATIENT'S SPOUSE: _____ __ PHONE #_____

REFFERED BY: _____

Main reason for today's visit: _____

Other Concerns: _____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	**Dose (e.g., mg/pill)**	**Reasons For Each**

Allergies or reactions to medications and/or creams: _____

PERSONAL MEDICAL HISTORY: Please indicate whether you currently have or have had any of the following medical conditions (with dates).

- ❑ Acne
- ❑ Auto-Immune Disease
- ❑ Cardiac Disease
- ❑ Cancer
- ❑ Diabetes
- ❑ Eating Disorder
- ❑ Epilepsy/Seizure Disorders
- ❑ Recent Fever/Cold/Flu
- ❑ Gastrointestinal
- ❑ Hypertension
- ❑ HIV/AIDS
- ❑ Kidney Disorders
- ❑ Liver Disorders
- ❑ Lymphatic Disorders
- ❑ Lipomas (Fatty Tumors)
- ❑ Neurological
- ❑ Organ Transplant
- ❑ Psychiatric
- ❑ Recent Weight Gain
- ❑ Recent Weight Loss
- ❑ Skin Conditions (i.e. rash, sensitivity)

If you have checked any of the boxes in the Personal Medical History section, please describe what steps have been taken to treat these conditions:

_____

_____

_____

SURGICAL HISTORY: Please list all prior operations (with dates):

_____

_____

_____

_____

FAMILY HISTORY:

_____

_____

_____

1. As a result of any surgeries, do you have any metal implants? **YES / NO**

   If yes, please explain where: _____

2. Do you have any open wounds or present burns in the area you are requesting treatment? **YES / NO**
3. Do you have feeling, both superficially and deeply in the area you are requesting treatments? (This is very important, because patient feedback is necessary to achieve safe and effective results.) **YES / NO**
4. Do you currently have any electrical support systems in your body (i.e. pacemakers, automatic defibrillator, cardioverter)? **YES / NO**

   If yes, please list: _____

5. Do you have any other type of implantable devices? **YES / NO**

   If yes, please list: _____

PREGNANCY & CONTRACEPTIVES:

1. Are you currently menstruating? **YES / NO** LMP Date: _____
2. If you are a women, are you currently pregnant, or is there a possibility that you are pregnant? **YES / NO**
3. Are you currently trying to get pregnant? **YES / NO**
4. Are you currently on birth control? **YES / NO**
5. Are you currently breast feeding? **YES / NO** If yes, please list: _____
6. If you have delivered a child, what type of delivery did you have? **Cesarean Section / Vaginal**
7. Do you have a Tubal Ligation? **YES / NO**
8. If you have had tubal ligation, what material is your clip made of? **Titanium / Plastic**
9. Do you have an IUD? **YES / NO**
10. If yes, which of the following material does it contain? **Copper / Hormones**

SOCIAL HISTORY:

1. Are you currently using or do you have a history of tobacco use? **YES / NO**

2. If yes, please list: packs/day _____ Other: _____ No. of years: _____
3. Are you currently using or do you have a history of illegal drug use? **YES / NO**
4. Please describe your alcohol consumption:

Daily / Weekly / Monthly / Occasionally / Rarely / Never

5. Please describe your caffeine intake: **None / Coffee / Tea / Soda** _____ cups/day

OTHER:

Are you being treated for any other conditions not listed? If so, please explain:

_____

_____

_____

Is there any other information that you feel may be related to or is pertinent to your treatment? If so, please explain._____

_____

_____

_____

_____ _____

(Patient Signature) **(Date)**