

# Medical History Information

We are here to help you. Please answer truthfully and completely as possible.

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## Do you have:

Heart disease	___ Yes ___ No	Bulimia or anorexia	___ Yes ___ No
Autoimmune disorder	___ Yes ___ No	Chronic illness	___ Yes ___ No
Asthma	___ Yes ___ No	Mental illness	___ Yes ___ No
Drug dependency	___ Yes ___ No	Blood clotting disorder	___ Yes ___ No
Anemia	___ Yes ___ No	Depression	___ Yes ___ No
Lung disease	___ Yes ___ No	High blood pressure	___ Yes ___ No
Blood disorder	___ Yes ___ No	Cancer	___ Yes ___ No
Serious accident	___ Yes ___ No	Diabetes	___ Yes ___ No
Birth control	___ Yes ___ No	Sleep apnea	___ Yes ___ No
Type _____		CPAP machine	___ Yes ___ No
Latex allergies	___ Yes ___ No	Environmental allergies	___ Yes ___ No
Other: _____			

If you answered yes to any of the above, please explain:

\_\_\_\_\_

\_\_\_\_\_

Do you have any allergies to medication? Yes / No

If you answered yes, please list and describe reaction:

\_\_\_\_\_

\_\_\_\_\_

Do you take any anti-depressants? Yes / No

If you answered yes, please list:

\_\_\_\_\_ Physician prescribing them: \_\_\_\_\_

Please list ALL medications and herbal supplements you are taking:

\_\_\_\_\_

\_\_\_\_\_

Have you had any cosmetic procedures? Yes / No

If yes, were you happy with the outcome? Yes / No

List all previous surgeries (Including cosmetic procedures):

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Complications: \_\_\_\_\_

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Complications: \_\_\_\_\_

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Complications: \_\_\_\_\_

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Complications: \_\_\_\_\_

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Complications: \_\_\_\_\_

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Complications: \_\_\_\_\_

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Complications: \_\_\_\_\_

## Childbirth

Is there a chance you are or could be pregnant right now? Yes / No

Number of pregnancies? \_\_\_\_\_ Number of children? \_\_\_\_\_ Age(s) of children: \_\_\_\_\_

## Lifestyle

Do you smoke? Yes / No Packs per day? \_\_\_\_\_ Number of years \_\_\_\_\_ When did you quit? \_\_\_\_\_

How many drinks containing alcohol do you drink in a week? \_\_\_\_\_

Do you take Aspirin or Ibuprofen on a regular basis? Yes / No

Are you on a diet pill or diet program now? Yes / No Have you been in the last 3 years? Yes / No

Do you exercise? Yes / No Activity: \_\_\_\_\_ How Often? \_\_\_\_\_

Please describe the reason for your visit: \_\_\_\_\_

How did you hear about Dr. Kaweski? \_\_\_\_\_

(Please be specific as we would like to thank them.)