Medical History Form

Date: _____

Legal First, Middle and Last Name: _____

Address: _____ City: _____ Postal Code: _____

E-Mail: _____ Home Phone: _____

Birth Date: _____ Cell Phone: _____

Family Physician: _____ Care Card# _____

Preferred method of contact: ☐ Cell Phone ☐ Home Phone ☐ Work Phone: _____

It is important that we are aware of your general health and medical background. In some instances this can critically affect the safety of some procedures. This information will be kept confidential. Please assist Dr. Mosher by completing the following information:

Reason For Visit:

Please indicate which procedure(s) or area of improvement you would like to discuss with Dr. Mosher:

_____

Your Past Medical History: Do you have, or have you had any of the following conditions:

Asthma	☐ YES	☐ NO	Details_____
Autoimmune Disorders	☐ YES	☐ NO	Details_____
Bleeding or Bruising Disorder	☐ YES	☐ NO	Details_____
Blood Clotting Disorder	☐ YES	☐ NO	Details_____
Breast Cancer	☐ YES	☐ NO	Details_____
Cancer	☐ YES	☐ NO	Details_____
Heart Disease	☐ YES	☐ NO	Details_____
Heart Murmur	☐ YES	☐ NO	Details_____
Chest Pain/Tightness	☐ YES	☐ NO	Details_____
Diabetes	☐ YES	☐ NO	Details_____
Hepatitis A	☐ YES	☐ NO	Details_____
Hepatitis B or C	☐ YES	☐ NO	Details_____
Liver Disease	☐ YES	☐ NO	Details_____
High Blood Pressure	☐ YES	☐ NO	Details_____
Lymphatic System Disease	☐ YES	☐ NO	Details_____
HIV or AIDS	☐ YES	☐ NO	Details_____
Hives	☐ YES	☐ NO	Details_____
Kidney Stones	☐ YES	☐ NO	Details_____
Skin Cancer	☐ YES	☐ NO	Details_____
Skin Disease	☐ YES	☐ NO	Details_____
Keloid Scarring	☐ YES	☐ NO	Details_____
Radiation / X-Ray Therapy	☐ YES	☐ NO	Details_____
Rheumatoid Arthritis	☐ YES	☐ NO	Details_____
Seizures	☐ YES	☐ NO	Details_____
Stroke	☐ YES	☐ NO	Details_____
Thyroid Disorder	☐ YES	☐ NO	Details_____
Tuberculosis	☐ YES	☐ NO	Details_____
Ulcers	☐ YES	☐ NO	Details_____
Other	☐ YES	☐ NO	Details_____

Patient acknowledges they **do not** have any significant past medical conditions as noted above: ☐ YES ☐ NO

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Factors That May Influence Coagulation (Blood-Clotting Factors)

I am using birth control pills ☐ YES
I have previously had a leg or lung blood clot ☐ YES
I am taking hormone supplements ☐ YES
None of the above ☐ YES

Patient Past Surgeries/Hospitalizations (if none, please write "None")

Surgery/Hospitalization_____ Date_____
Anesthesia Complications ☐ YES ☐ NO Details_____
Notes_____

Surgery/Hospitalization_____ Date_____
Anesthesia Complications ☐ YES ☐ NO Details_____
Notes_____

Surgery/Hospitalization_____ Date_____
Anesthesia Complications ☐ YES ☐ NO Details_____
Notes_____

Surgery/Hospitalization_____ Date_____
Anesthesia Complications ☐ YES ☐ NO Details_____
Notes_____

Patient Family History

Abnormal Bleeding ☐ YES Afflicted Family Member_____ Notes_____
Abnormal Blood Clotting ☐ YES Afflicted Family Member_____ Notes_____
Anesthesia Problems ☐ YES Afflicted Family Member_____ Notes_____
Autoimmune Disorders ☐ YES Afflicted Family Member_____ Notes_____
Breast Cancer ☐ YES Afflicted Family Member_____ Notes_____
Diabetes ☐ YES Afflicted Family Member_____ Notes_____
Heart Disease ☐ YES Afflicted Family Member_____ Notes_____
Malignant Hyperthermia ☐ YES Afflicted Family Member_____ Notes_____
Other Cancer ☐ YES Afflicted Family Member_____ Notes_____
Ovarian Cancer ☐ YES Afflicted Family Member_____ Notes_____
Prostate Cancer ☐ YES Afflicted Family Member_____ Notes_____

Patient acknowledges they **do not** have any contributing family history of the conditions as noted above: ☐ YES ☐ NO

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Mental Health Concerns

Do you have any mental health concerns?

Depression	☐ YES	☐ NO	Details_____
Bi-Polar Disorder/Mania	☐ YES	☐ NO	Details_____
Seasonal Affective Disorder	☐ YES	☐ NO	Details_____
Anxiety	☐ YES	☐ NO	Details_____
Schizophrenia	☐ YES	☐ NO	Details_____
Dysmorphic Disorder	☐ YES	☐ NO	Details_____
Other	☐ YES	☐ NO	Details_____

Patient Social History (if "yes" please provide details)

Alcohol Use Socially	☐ YES	☐ NO	Details_____
Alcohol Use Daily	☐ YES	☐ NO	Details_____
Illegal Drug Use	☐ YES	☐ NO	Details_____
STD History	☐ YES	☐ NO	Details_____

Patient Smoking History (if "yes" please provide details)

Marijuana Use	☐ YES	☐ NO	Details_____
Are you a smoker?	☐ YES	☐ NO	(If "NO", skip to next section)
Chewing Tobacco Use	☐ YES	☐ NO	(If "NO", skip to next section)
Smokes <1 pack/day	☐ YES	☐ NO	Details_____
Smokes 1 pack/day	☐ YES	☐ NO	Details_____
Smokes >1 pack/day	☐ YES	☐ NO	Details_____
Smoked for < 5 years	☐ YES	☐ NO	Details_____
Smoked for > 5 years	☐ YES	☐ NO	Details_____
Quit < 1 year ago	☐ YES	☐ NO	Details_____
Quit 1- 5 years ago	☐ YES	☐ NO	Details_____
Quit > 5 years ago	☐ YES	☐ NO	Details_____

Allergies (if none, please enter "None")

Allergy_____ Reaction_____

Notes _____

Allergy_____ Reaction_____

Notes _____

Allergy_____ Reaction_____

Notes _____

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Current Medications (if none, please enter "None")

1. Drug_____ Dosage_____

Prescribed By_____ Bad Reaction? _____

2. Drug_____ Dosage_____

Prescribed By_____ Bad Reaction? _____

3. Drug_____ Dosage_____

Prescribed By_____ Bad Reaction? _____

4. Drug_____ Dosage_____

Prescribed By_____ Bad Reaction? _____

5. Drug_____ Dosage_____

Prescribed By_____ Bad Reaction? _____

6. Drug_____ Dosage_____

Prescribed By_____ Bad Reaction? _____

Patient Ability to Heal

Is your skin fragile or very slow to heal?	☐ YES	☐ NO	Details_____
Do you form thick or raised scarring from a cut or burn?	☐ YES	☐ NO	Details_____
Do you wax or use depilatories on your face?	☐ YES	☐ NO	Details_____
Do you ever get cold sores?	☐ YES	☐ NO	Details _____
Have you ever taken Accutane?	☐ YES	☐ NO	Details _____

Female Questions

Do you have regular periods?	☐ YES	☐ NO	☐ N/A
Are you going through Menopause?	☐ YES	☐ NO	☐ N/A
Are you pregnant or lactating?	☐ YES	☐ NO	☐ N/A
During pregnancy, did you ever get hyperpigmentation or masking?	☐ YES	☐ NO	☐ N/A
Have you ever experienced multiple miscarriages?	☐ YES	☐ NO	☐ N/A
Are you frequently anemic?	☐ YES	☐ NO	☐ N/A

Height / Weight

Height _____ ft _____inches Weight _____pounds

Medical History Verification

All information provided above is accurate and complete to the best of my knowledge.

Patient Signature_____ **Date**_____

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