illume
COSMETIC SURGERY & MEDSPA

# Medical History
## (Please print clearly)

Full Name: _____ Birth date: _____ ☐Male ☐Female

Height:_____Weight:_____

Patient Signature: _____ Date: _____

Are you **CURRENTLY** being treated for any of the following? Check all that apply or Circle: **NONE APPLY**

**Constitutional:**
___Fever
___Weight change
___Fatigue

**Respiratory**
___Wheezing
___Cough
___Asthma

**Musculoskeletal**
___Swelling
___Arthritic joint pain
___Numbness

**Ear/Nose/Mouth/Throat**
___Ringing in the ears
___Hearing loss
___Sores in mouth

**Gastrointestinal**
___Stomach pain
___Nausea/Vomiting
___Diarrhea

**Skin**
___Rashes
___Sores
___Eczema

**Cardiovascular**
___Chest pain
___Irregular heart beat/murmur
___High blood pressure

**Genitourinary**
___Painful urination
___Blood in urine
___Enlarged prostate

**Neurological**
___Headaches
___Dizziness
___Multiple sclerosis
___Stroke
___Seizure

**Rheumatological**
___Lupus
___Scleroderma
___Dry mouth/ dry eyes
___Arthritis
___Polymyositis
___Psoriasis
___Raynauds
___Chronic fatigue
___Fibromyalgia
___Lyme disease

**Endocrine/Immune**
___Diabetes
___Thyroid disease
___HIV

**Hematological**
___Bruising
___Excessive bleeding
___Sickle cell + / -
___Hepatitis

**Psychiatric**
___Anxiety
___Depression

**Other health problems:** _____

**Previous surgeries:** _____

**Medications:** _____

**Medication allergies & reactions:** _____

**Primary care provider:** _____ **Location:** _____

**Other specialist? Psychiatrist? Cardiologist?** Please name: _____

**Do you smoke?** Yes / No How much? _____
**Former smoker?** Yes / No Quit date: _____
Please circle if YES:
**Nicotine gum/patch** **Marijuana** **Vape:** _____
**Other drugs?** _____
**Do you drink alcohol?** Yes / No How much? _____

**Do you take Aspirin?** Yes / No
**Other blood thinners?** Yes / No
(Med: _____)
**Vitamin E?** Yes / No
**Fish oil?** Yes / No

**<u>Do you have a PERSONAL history of?</u>**

**High Blood Pressure** Yes / No
Do you take your BP @ home? Yes / No
Is BP usually: High / Low / Normal?
**Heart Problems** Yes / No
**Blood clots (DVT, PE)** Yes / No

**Diabetes?** Yes / No
Do you take blood sugar at home? Yes / No
Is it: High / Low / Normal?
**Seizures** Yes / No
**Stroke** Yes / No