

MEDICAL HISTORY

Please answer all questions. If a question does not pertain to your medical history or the answer is no, please mark no in the area provided or mark N/A. Thank you.

NAME _____ DATE _____
DATE OF LAST PHYSICAL EXAM _____ DOCTOR _____

SURGERY (cosmetic and non-cosmetic surgery):
TYPE DATE COMPLICATIONS OR DIFFICULTIES

- 1. _____
- 2. _____
- 3. _____
- 4. _____

ADMISSIONS TO HOSPITAL:
REASON DATE COMPLICATIONS OR DIFFICULTIES

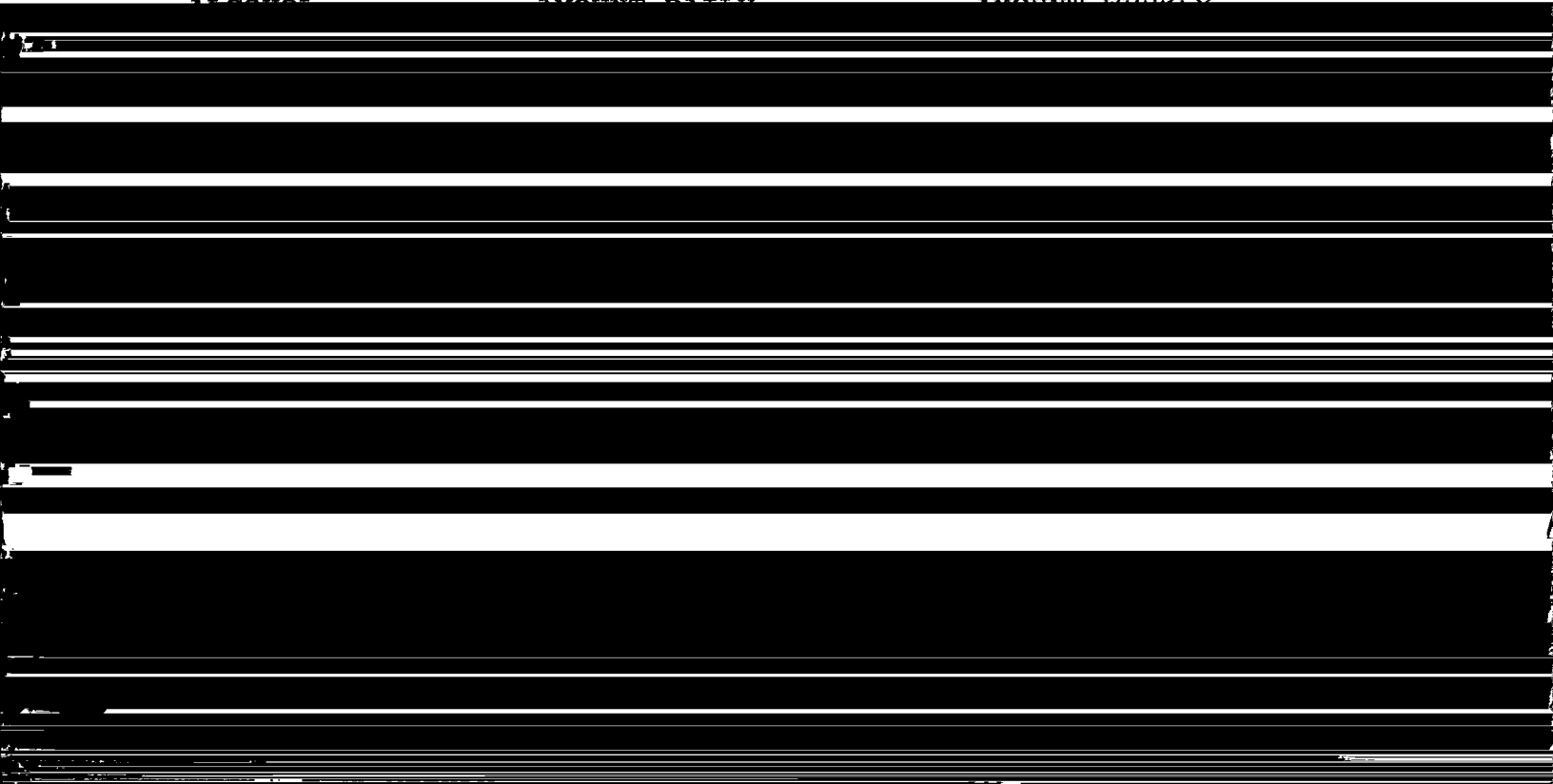
- 1. _____
- 2. _____
- 3. _____

MEDICATIONS (any drug or medicine) YOU TAKE NOW:
TYPE DOSAGE, AMOUNT IF KNOWN TAKEN HOW OFTEN

- 1. _____
- 2. _____
- 3. _____

CONSUMPTION OF THE FOLLOWING:

ASPIRIN _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____
~~ALCOHOL~~ ~~AMOUNT DAILY~~ ~~AMOUNT WEEKLY~~



HAVE YOU EVER BEEN EXPOSED TO:

YES _____	NO _____	INTRAVENOUS DRUGS
YES _____	NO _____	INFECTIOUS DISEASES
YES _____	NO _____	TB
YES _____	NO _____	AIDS
YES _____	NO _____	HEPATITIS

HISTORY OF EPILEPSY OR MENTAL ILLNESS: YES NO