Signature

## Health Information as of \_\_\_\_\_ (enter today's date) (Please Print Legibly & Fill In or Correct All Fields) **Patient's Name** Middle Age Birthdate Height Weight Gender ☐ Female ☐ Male Purpose of Visit: **Previous Surgeries with Dates:** (Including cosmetic) **Health Problems Past & Present:** (mark all that apply) Diabetes ☐ High Blood Pressure ☐ Heart Problems ☐ Easy Bruising ☐ Lung/Breathing Problems ☐ Bleeding/Clotting Problems ☐ Psychiatric / Depression ☐ Cancer Other: Please explain all positive responses: **Do you smoke?** □ No □ Yes, How many packs a day? **Medications:** (include all Prescriptive, Over-The-Counter, Vitamins and Herbal medications taken regularly) **Drug or Latex Allergies:** (please indicate if none) **Primary Physician** First and Last Name Date of Last Physical: The above information is accurate and complete to the best of my knowledge.

Date