Jouvence Aesthetics

MEDICAL HISTORY

NAME____ DATE______________

DATE OF YOUR LAST PHYSICAL EXAMINATION______________________ WEIGHT__________ HEIGHT__________

SURGERY (OPERATIONS AND COSMETIC SURGERY)

TYPE DATE COMPLICATIONS OR DIFFICULTIES

1.____
2.____
3.____
4.____
5.____
6.____

MEDICAL PROBLEMS OR CONDITIONA NOW UNDER TREATMENT BY A PHYSICIAN

EXPLAIN ____

____

____

ADMISSIONS TO HOSPITAL

REASON DATE COMPLICATIONS OR DIFFICULTIES

1.____
2.____
3.____
4.____

MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS YOU TAKE NOW

TYPE DOSAGE/AMOUNT IF KNOWN TAKE HOW OFTEN

1.____
2.____
3.____
4.____

CONSUMPTION OF THE FOLLOWING

ASPIRIN______________ AMOUNT DAILY______________ AMOUNT WEEKLY______________

ALCOHOL______________ AMOUNT DAILY______________ AMOUNT WEEKLY______________

TOBACCO______________ AMOUNT DAILY______________ AMOUNT WEEKLY______________

OTHERS______________ AMOUNT DAILY______________ AMOUNT WEEKLY______________

BLEEDING PROBLEMS

DO YOU BRUISE OR BLEED EASILY? YES NO (WITH CUTS / TOOTH EXTRACTIONS / PREGNANCY / SURGERY)

EXPLAIN____

DO YOU HAVE A FAMILY HISTORY OF BLEEDING PROBLEMS? EXPLAIN______________________________

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA

EXPLAIN____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO

ARE YOU PREGNANT? YES NO

HAVE YOU EVER HAD, HAVE OR BEEN EXPOSED TO (PLEASE CIRCLE YES OR NO)

YES NO INTRAVENOUS DRUGS
YES NO INFECTIOUS DISEASES
YES NO TB
YES NO HEPATITIS
YES NO HIV / AIDS
YES NO LIVER TRANSPLANT

IF YES TO ANY EXPLAIN____

____

HISTORY OF EPILEPSY OR MENTAL ILLNESS

EXPLAIN____

____

CHILDHOOD MEDICAL HISTORY (PLEASE CIRLE YES, NO OR UNCERTAIN)

HAD ALL KNOWN "BABY SHOTS"?	YES	NO	UNCERTAIN
HAD POLIO IMMUNIZATION?	YES	NO	UNCERTAIN
HAD RHEUMATIC FEVER?	YES	NO	UNCERTAIN

FAMILY HISTORY

ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?

MOTHER________________________________

____

FATHER________________________________

____

SISTER________________________________

____

BROTHER________________________________

____

OTHER RELATIVE:____

REVIEW OF SYSTEMS

ANY MEDICAL PROBLEMS WITH ANY OF THE FOLLOWING:

NO_______ HEAD, IF YES EXPLAIN________________________________

NO_______ EYES, IF YES EXPLAIN________________________________

NO_______ EARS, IF YES EXPLAIN________________________________

NO_______ THYROID, IF YES EXPLAIN________________________________

NO_______ LUNGS, IF YES EXPLAIN________________________________

NO_______ HEART, IF YES EXPLAIN________________________________

NO_______ BLOOD PRESSURE OR VESSELS, IF YES EXPLAIN________________________________

NO_______ DIGESTIVE SYSTEMS, IF YES EXPLAIN________________________________

NO_______ LIVER, IF YES EXPLAIN________________________________

NO_______ MUSCLES-BONES, IF YES EXPLAIN________________________________

NO_______ REPRODUCTIVE ORGANS, IF YES EXPLAIN________________________________

NO_______ KIDNEY'S-BLADDER, IF YES EXPLAIN________________________________

NO_______ UNSIGHTLY SCARS, IF YES EXPLAIN________________________________

NO_______ OTHER, IF YES EXPLAIN________________________________

NO_______ DISEASE AFFECTING IMMUNE SYSTEM, IF YES EXPLAIN________________________________

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATION(S)? PLEASE LIST

____

____

____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PRACTICE NAME:____

PHYSICIAN:____

ADDRESS:____

BY REPRESENTATION OF SIGNATURE BELOW, I HEREBY AUTHORIZE THE ABOVE STATED OFFICE TO FORWARD MY MEDICAL RECORDS TO:

Jouvence Aesthetics

201 W 21st St 1H, New York, NY 10010

________________________________ ________________________________

PATIENT SIGNATURE **Phone (781) 254-3091** DATE

Website: www.jouvence-ny.com

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PRINTED NAME