AESTHETICS & WEIGHTLOSS

3 Mobile Infirmary Circle • Suite 303 • Mobile, AL 36607 • 251-434-0005

Last Name: First Name: Middle: Gender Birth date Age

Primary Physician/Referral: Physician Phone Number:

HEALTH HISTORY: (F = family P = personal)

	F	P		F	P
Alcohol Abuse	☐	☐	Gallbladder Disorder	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐
Arthritis	☐	☐	Headaches	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐
Bleeding Disorder	☐	☐	High cholesterol	☐	☐
Bloody Stool	☐	☐	Hypertension	☐	☐
Bronchitis	☐	☐	Insomnia	☐	☐
Bronchitis	☐	☐	Irregular pulse	☐	☐
Cancer	☐	☐	Kidney Disease	☐	☐
Chest Pain	☐	☐	Liver Disease	☐	☐
Constipation	☐	☐	Lung Disease	☐	☐
Convulsions	☐	☐	Mental Illness	☐	☐
Depression	☐	☐	Migraines	☐	☐
Diabetes	☐	☐	Moodiness	☐	☐
Diarrhea	☐	☐	Nervousness	☐	☐
Dizzy Spells	☐	☐	Obesity	☐	☐
Drug Abuse	☐	☐	Palpitations	☐	☐
Eating Disorder	☐	☐	Rashes	☐	☐
Epilepsy	☐	☐	Shortness of Breath	☐	☐
Fainting Spells	☐	☐	Stroke	☐	☐
Fatigue	☐	☐	Thyroid Disease	☐	☐
Frequent Urination	☐	☐	Comments/Other:		

ALLERGIES:

SURGERIES AND OTHER HOSPITALIZATIONS:

Year Reason/Diagnosis Hospital

PRESCRIBED MEDICATIONS & OVER-THE-COUNTER DRUGS:

Medication Name	Strength	Frequency

HEALTH HABITS & PERSONAL SAFETY:

Caffeine

Rank your caffeine intake:	□High	□Medium	□Low	□None
What types of caffeine do you drink?		□Coffee	□Tea	□Soda
How many cups/cans per day?				

Alcohol

Do you drink alcohol?			□ Yes	□No
If yes, what kind?		□Beer	□Liquor	□Wine
How many drinks per week?				

Tobacco

Do you use tobacco?			□Yes	□No
□Cigarettes - packs/day:	□Chew - #/day:	□Pipe - #/day:	□Cigars - #/day:	
How many years?				
If you previously used tobacco, what year did you quit?				

Exercise

□Sedentary (no exercise)

□Mild Exercise (i.e. climbing stairs, walking three blocks, golf)

□ Occasional vigorous exercise (i.e., work or recreation less than 4 times per week for 30 minutes)

□ Regular vigorous exercise (i.e., work or recreation 4 times per week or more for 30 minutes or more)

Women Only

Are you sexually active?			□Yes	□No
If yes, are you trying to get pregnant?			□Yes	□No
If you are not trying for a pregnancy, what contraceptive methods are you using?				
How often do you get your period (days)?		Number of pregnancies:		Number of births:
Are you pregnant or breastfeeding?			□Yes	□No

ACCURACY AGREEMENT:

I hereby agree that the information contained in this medical history is accurate to the best of my knowledge.

Signature _____ Date _____