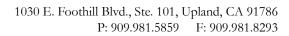


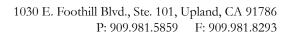
Past Medical History:

Today's date:		Primary/Referring doctor:								
Last name:				First name:		Age:	Date of birth:			
Occupation:							Gender: Male Female			
Chief Complaint:		What br	rings you in to see	the doctor?						
History of Prese	nt Illness		tell us more abouments tried, thing			-				
Review of Syster	ms:	Do you	have any of the fo	ollowing sympt	oms? Please	check all that a	pply.			
Head:		Eyes:		Mouth:		Ears:				
Headache		Blurry	vision Tooth j			Hearing loss (I	L/R)			
Facial pressure	Double	vision	Difficulty swall	owing Diz	ziness					
Facial pain		Blindne	ess (L/R) Mouth	Pain		Ringing (L / R	)			
Facial droop		Itchy ey		Snoring		Drainage (L/R	2)			
Facial numbness	Watery	eyes	Loss of	f taste		Pain $(L/R)$				
				_		Itchin	g(L/R)			
Nose:		Neck:		General:						
Runny	Masses		Fatigue		ırtburn					
Dry		Pain	_	Weight loss		Nause	ea e e e e e e e e e e e e e e e e e e			
Bleeding (L/R)			-		Vomitin	_				
Loss of smell	Hoarser	ness	Chest		_	Bloody/tarry st	tools			
Stuffy (L/R)	Cough		Shortness of bre	eath	Frequen	t urination				
Urgency		Itchy sk	cin	Nervousness		Easy bruising				
Back pain		Skin ras		Trouble sleep		Excessive thirs	st			
Joint pain			ess/tingling	Daytime slee			cold intolerance			
Joint stiffness	Hyperac		Easy bleeding	-	ction to envir					
John Stiffiess	Пурсти	otivity	Easy orceaning	Ttea	etion to envir	omnem				
Other conditions	not listed	[								
Have you had any	y surgery	? Please	list with dates:							
						-				





Glaucoma	Thyroid disease		Renal 1	failure	Cancer			
Cataracts	Bleeding disorders	Anxiety		Heada	che			
Blindness (L / R)	HIV		Depres	sion		Other		
Stroke	Sleep apnea	ADHD		Other		_		
Brain aneurysm	Asthma		Arthrit	is	Other _			
Anemia	Emphysema/COPD	Sjogren'	s diseas	se				
High blood pressure	Bronchitis	Lupus						
Heart disease	Pneumonia	Myasthe						
Heart attack	GERD		Multip	le sclero	sis			
Atrial fibrillation	Stomach ulcers		Diabet	es				
High cholesterol	Hepatitis	Fibromy	algia					
Medications:	Please list any medication	s you are	currentl	y taking:	1			
	Name		Strength/Amount			How often		
		1: .: .			37	N.		
Allergies:	Are you allergic to any medications? Yes No  If yes, please list:							
Family History: Are th	e any medical problems that	run in you	ır famil	y?				
	Father:							
	Mother:					<del></del>		
	Other:							
Social History:	Do you use tobacco?		Yes	No	If yes	s, how many cigarettes a day?		
•	•					many years have you smoked?		
	Do you drink alcohol?		Yes	No	If yes	s, how many drinks per day?		
	Do you use illicit drugs?		Yes	No		s, what kind?		
	Do you drink caffeine?		Yes	No	If yes	s, how many cups per day?		
	Do you add salt to your fo	ods? Yes	S	No				





## Skin History

Describe your history of:									
Sun Exposure: Skin C	Cancer: Acne:				_				
Have you ever had Accutane treatment:	Other skin problems:	Other skin problems:							
Social and Personal	Mental Health								
Do you exercise regularly? Yes 🔲 No 🚨	Is stress a major problem for you?	Yes		No					
/week or/month	Do you feel depressed?	Yes		Νo					
Contison: Injection in the past year? Yes 🔲 No		Yes	ш	No	ш				
Have you ever used tobacco? Yes \(\sigma\) No \(\sigma\) If yes, average # packs per day?  Number of years smoking: Years quit	cating / your appetite?  Do you cry frequently?	Yes Yes Yes							
	Do you have trouble sleeping?	Yes		No					
Do you drink alcohol? Yes ☐ No ☐ If yes, how many drinks per week?	Have you ever been to a counselor?	$\mathbf{Y}_{\mathbf{C}\mathbf{x}}$		No					
Ever used LSD / Speed / Cocame / Manjuana? Yes  No  When?	Have you ever taken psychiatric Medication(s) <sup>5</sup>	Yes	0	No	0				
Recent weight change? Yes □ No □	Do you currently take psychiatric								
If yes,  Increase (up) OR Decrease (down)	Medication(s)?	Yes	ш	No	ш				
	Should you have cosmetic surgery, pl you anticipate your life being differer procedure?				W				
I acknowledge that the information stated above is true and	d complete to the best of my knowledge.								
Patient/ Guardian Signature Patient/ Guard	dian name Date								
Reviewing Physician Signature Date									