DR. JAMES ARONOVITZ | Hair & Facial Plastics INSTITUTE

PATIENT NAME _____ DATE _____

REASON FOR VISIT TODAY _____

MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING?

ASTHMA	YES	NO
BRONCHITIS	YES	NO
HISTORY OF BLOOD TRANSFUSIONS	YES	NO
DIABETES	YES	NO
HYPOGLYCEMIA	YES	NO
LIVER DISEASE / JAUNDICE	YES	NO
HISTORY OF TB	YES	NO
HISTORY OF KIDNEY STONES	YES	NO
HEART PROBLEMS	YES	NO

If yes, explain _____

HIGH BLOOD PRESSURE	YES	NO
THYROID PROBLEMS	YES	NO
HEPATITIS	YES	NO
BLEEDING PROBLEMS	YES	NO
HISTORY OF CANCER	YES	NO
ALLERGIES	YES	NO

If yes, explain _____

ALLERGIC TO MEDICINE	**YES**	**NO**

If yes, explain _____

DO YOU SMOKE?	**YES**	**NO**

CIGARETTES? CIGARS? PIPE? CHEWING TOBACCO?

HOW MANY PER DAY?

HOW LONG DID OR HAVE YOU SMOKED?

HOW LONG AGO DID YOU QUIT?

DOES ANYONE IN THE HOME SMOKE?

DO YOU CONSUME ALCOHOL?

_____ BEERS? DAILY? WEEKLY?

_____ GLASSES OF WINE? DAILY? WEEKLY?

_____ HARD LIQUOR? DAILY? WEEKLY?

DOES ANYONE IN YOUR IMMEDIATE FAMILY HAVE ANY OF THE FOLLOWING?

HEART DISEASE	YES	NO
HIGH CHOLESTEROL	YES	NO
HIGH BLOOD PRESSURE	YES	NO
STROKE	YES	NO
ALLERGIES	YES	NO
CANCER	YES	NO
DIABETES	YES	NO

HIV / AIDS RISK FACTORS? _____

PREVIOUS SURGERIES? _____

OTHER MEDICAL CONDITIONS? _____