PATIENT HEALTH HISTORY

PLEASE PRINT: Please answer all of the questions as accurately as possible.

General Patient Information

Date:_____

Patient Name: Last _____ **First** _____ **MI**_____

SS# _____ **Birthdate** _____/_____/_____ **Age:** _____ **Gender:** □ **M** □ **F**

Address: _____

City/State/Zip: _____

Home Phone: _____ **Day Phone:** _____ **Cell Phone:** _____

HEIGHT _____ **feet** _____ **inches** **WEIGHT:** _____**lbs/ kg**

May We Leave Messages on Answering Machine: YES OR NO

Marital Status: M/D/S/W Spouse's Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Family Doctor: _____ Phone: _____

Referring Doctor: _____ Phone: _____

Occupation: _____ Place of Employment: _____

How did you hear about us? _____

Email: _____

Preferred Pharmacy: _____ Pharmacy Number:_____

INSURANCE INFORMATION
Name of Insurance Company: _____
Policy# or ID: _____ **GROUP #** _____
Policy Holder (if different from abovementioned patient):
_____ **DOB** _____

Current Medications
(Check all that apply provide product name)

- ○ **Non-steroidal anti-inflammatory or Pain Medication:** _____
- ○ **Aspirin:** _____
- ○ **Blood Pressure:** _____
- ○ **Topical Steroids:** _____
- ○ **Steroids:** _____
- ○ **Hormones:** _____
- ○ **Insulin:** _____
- ○ **Weight Reduction Meds:** _____
- ○ **Have you ever taken weight reduction meds?** _____
- ○ **Blood Thinners:** _____
- ○ **Anti- seizure Meds:** _____
- ○ **Antibiotics:** _____

Medications Continued…

- Arthritis Meds: _____
- Herbals: _____
- Tranquilizers/Sedatives: _____
- Vitamins: _____
- Sleeping Pills: _____
- Minerals: _____
- Iron: _____
- Barbiturates: _____
- Birth Control Pills: _____
- Asthma Med/Inhaler: _____
- Allergy Meds: _____
- Decongestants: _____
- Laxatives: _____
- Antidepressants: _____
- Others: _____

Allergies Reactions
(provide reactions)

- Medication: _____

_____

- Latex: _____
- Other: _____

Past Surgeries/Tests

Date of Last Mammography: _____ Results: _____

Date of Last Physical: _____ Results: _____

Past Surgeries: _____

_____

Conditions/Illnesses
Check all that apply.

- Anemia
- Anxiety/Stress
- Anesthesia problems
- Arthritis
- Asthma
- Bleeding tendency
- Cancer
- Chest pains
- Depression
- Diabetes
- Dizziness
- Easy bruising/bleeding
- Epilepsy
- Fainting
- Gastrointestinal
- Goiter
- Heart attack
- Heart disease
- Heart palpitation or pain
- Hepatitis
- Herpes
- High blood pressure
- High Cholesterol
- Keloids/thick scars
- Kidney problems
- Latex allergy
- Migraine
- Mitral valve prolapse
- Palpitations
- Physical defect or deformity
- Rash/new or change in mole
- Rheumatic fever
- Rosacea
- Stomach ulcer
- Stroke
- Thyroid trouble
- Tuberculosis
- Ulcers
- Unexplained weight loss/gain

Family History
(Which blood relative?)

Maternal	Paternal

○ **Breast Cancer:** _____ ○ **Melanoma:** _____	○ **Breast Cancer:** _____ ○ **Melanoma:** _____

Social History

Cigarette Use:

- ○ **I currently smoke cigarettes. Packs/Day:** _____

Alcohol Use:

Do you drink alcohol? Yes or No #of drinks/week: _____ **Is your alcohol a concern for you or others? Yes or No**

Please describe your concerns:

_____

_____

_____

How long this has been a concern?

_____

_____

What have you done to address this concern?

_____

_____

_____ _____

SIGNATURE **DATE**

Medical Release Form

Date: _____

Patient Name: Last _____ **First:** _____

Birthdate _____/_____/_____ **Age:** _____ **Gender: Male** _____ **Female** _____

Address: _____

City/State/Zip:

_____

Home Phone: _____ **Work:** _____ **Cell:** _____

Emergency Contact: _____ **Phone:** _____

Family Doctor: _____ **Phone:** _____

I (name) _____ **hereby release and discharge (Dr. Lisa Learn) Board certified plastic and reconstructive surgeon, along with all office staff from all claims of damage, demands, actions whatsoever in any manner arising or growing out of my participation in all cosmetic procedures. Including (Botox and juvederm,) injections. I have full knowledge as to the informational content of the procedure and or procedures, and I have full knowledge of the probable risks involved. I certify that I am healthy and fit to participate in this event.**

Signature _____ **Date** _____

Print Name _____

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1. Copyright same in the name of Dr. Learn or LL Plastic Surgery.
2. Use, re-use, publish the same in whole or in part, individually or in conjunction with other photographs, in any medium and for any purpose including, but not limited to publicity, illustration, promotion, advertising and trade.

I agree to release Dr. Learn and LL plastic Surgery from any valuable consideration in exchange for this release including, but not limited to, financial remuneration, services or products.

I release and discharge Dr. Learn and LL plastic Surgery and personnel from any and all claims and demands arising from, or in conjunction with, the use of photographs, including any and all claims for libel.

This authorization and release shall also insure the legal representative, licenses and assigns of Dr. Learn and LL plastic Surgery as well as the person or persons who took the photographs.

I am over the age of 18, or the parent of a subject under the age of 18 and am myself the legal age to execute agreements. I have read the foregoing and fully understand and agree to the contents thereof.

Signature: _____ **Date:** _____

Legal Guardian (if under 18): _____

Witnessed: _____