MEDICAL HISTORY

THE PURPOSE OF THIS FORM IS TO HELP ALL OUR PATIENTS HAVE THE BEST AND SAFEST TREATMENT PROVIDED. WE ASK YOU PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWELEDGE. THANK YOU

NAME____ TODAYS DATE_____________________________DATE OF BIRTH__________________

ALLERGIES TO MEDICATIONS:

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LIST ANY OPERATIONS YOU HAVE HAD:

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LIST ANY SERIOUS ILLNESS YOU HAVE HAD:

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LIST YOUR CURRENT MEDICATIONS WITH DOSAGES:

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FAMILY HISTORY OF ANY OF THE FOLLOWING:____

IF YOU HAVE HAD ANY OF THE FOLLOWING HEALTH ISSUSE PLEASE CIRCLE: YES OR NO. *IF YES PLEASE GIVE YOU OR YOUR FAMILY MEMBERS DIAGNOSIS*

NEUROLOGIC (Seizures, paralysis): YES / NO____

HIGH / LOW BLOOD PRESSURE: YES / NO____

KIDNEY/LIVER/UTERIN: YES / NO____

DIGESTIVE (GERD, Ulcers): YES / NO____

BONE / JOINT (Arthritis, Osteoporosis): YES / NO____

MUSCULAR WEAKNESS: YES / NO____

SKIN (Eczema, Psoriasis, Keloids): YES / NO____

DIABETES: YES / NO____

CANCER: YES / NO____

BLOOD DISORDERS: YES / NO____

STROKE / HEART CONDITION: YES / NO____

DRUG / ALCOHOLE ADDICTON: YES/ NO____

HIV/AIDS: YES / NO____

THYROID: YES / NO____

DO YOU SMOKE TOBACCO: YES / NO IF SO HOW MUCH: ____________________________________

WARNING: CIGARETTE SMOKING OR USE OF TOBACCO IS DETRIMENTAL TO WOUND HEALING AND CAN CAUSE THE FOLLOWING: SKIN TO TURN BLACK OR DIE, WOUND TO OPEN UP, INCREASES THE RISK OF INFECTION, AND DRASTICALLY SLOWS WOUND HEALING.

DR. KADESKY RECOMMENDS THAT YOU STOP SMOKING OR ANY USE OF TOBACCO. IF YOU CHOOSE TO CONTINUE THE USE OF TOBACCO YOU ARE ACCEPTING ALL RESPONSIBILITY FOR ALL THE ABOVE COMPLICATIONS. (PLEASE INITIAL______________________________**)**

PATIENT SIGNATURE:____