

Personal Enhancement Center History Sheet

Please Print

Name (First - Middle - Last)	Date
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Reason for your Visit

Have you seen any other physicians for this problem?	If so, name of doctor
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Referred By:

Height	Weight	DOB	Age	Loss	lb	Gain	lb
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Name and Address of Primary Physician

Please answer the following questions as accurately as possible:

Date of your last...			
Check-Up	Chest X-ray	Mammogram	
EKG	Blood Pressure	Other	
Blood Test	Tetanus		

Serious Illness (Please list all serious illnesses and dates)

1.) _____	4.) _____
2.) _____	5.) _____
3.) _____	6.) _____

Previous Surgery

Operation	Year	Hospital	City	Surgeon	Anesthesia

Have you had any complications with surgery?	(Circle One)	Yes / No	Type of complication:
If yes, please explain:			

Allergies

Food _____	Reaction _____
Drug _____	Reaction _____

Have you or are you presently taken or involved in any of the following?

Birth Control Pills <input type="checkbox"/>	Steroids, Cortisone or ACTH <input type="checkbox"/>
Acutane for the Treatment of Acne <input type="checkbox"/>	Hormonal Replacement Therapy <input type="checkbox"/>
Retin A <input type="checkbox"/>	Blood Thinner <input type="checkbox"/>

What is your daily consumption of the following?

Alcohol _____	Tobacco _____ (Packs per Day)
Coffee/Tea _____	Recreational Drugs _____

Please see reverse side

Personal Medical History

Place an X in the box if you have experienced any of the following conditions.

Arthritis	<input type="checkbox"/>
Asthma	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>
Blood Transfusions	<input type="checkbox"/>
Cancer	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>
Constipation	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>
Emotional Problems	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>
Eye Problems	<input type="checkbox"/>

Fainting	<input type="checkbox"/>
Female Problems	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>
Headaches	<input type="checkbox"/>
Hearing Problems	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>
Herpes	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>
Infections	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>
Keloid Scars	<input type="checkbox"/>
Liver Problems	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>

Palpitations	<input type="checkbox"/>
Pollen Allergies	<input type="checkbox"/>
Poor Teeth	<input type="checkbox"/>
Pregnancies	<input type="checkbox"/>
Psychiatric Counseling	<input type="checkbox"/>
Seizures	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>
Skin Diseases	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>
Stomach Ulcers	<input type="checkbox"/>
Stroke	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>

We can provide you with the best possible care when we are fully informed concerning your personal history. Thank you for being complete.

Today's Date _____	Your Signature _____
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FOR OFFICE USE ONLY

Diagnosis:	
Procedure:	

Length of Surgery:	Date Requested:
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Hospital/Surgery Center:	TRSC	SSC	OMC	JSUMC	CMH	OFFICE	OTHER: _____
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Length of Stay:	SDS	23 HOUR	ADMIT	OTHER: _____
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Type of Anesthesia:	LOCAL	MAC	SPINAL	GA	OTHER: _____
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Pre-Op Testing:	CBC	PT/PTT	SMA7	EKG	CXR	MAMMO	OTHER: _____
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Clearance:	MEDICINE	CARDIOLOGY	OPHTHOMOLOGY	PSYCH	OTHER: _____
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NOTES:	NURSES INITIALS:
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