MEDICAL HISTORY

Do you have any of the following?

Bleeding Problems	Y N	Kidney Disease	Y N
Difficulty Healing Wounds	Y N	High Blood Pressure	Y N
Keloids	Y N	Liver Disease/Hepatitis	Y N
Abnormal Scarring	Y N	Arthritis	Y N
Diabetes	Y N	Back or Neck Problems	Y N
Artificial Heart Valve	Y N	Fever Blisters	Y N
Pacemaker	Y N	Skin Cancer	Y N
Artificial Joints	Y N	Heart Disease	Y N
Lung Disease	Y N	Melanoma	Y N

If yes to any of the above, please explain: ______________________________

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Are you pregnant? ____

Why are you being seen today? ____________________________________

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Prior Hospitalization/Surgery:_____________________________________

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Current Medications: ____

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Allergies: ____