



**Cedars
Minimally
Invasive
Surgical
Suite, PC**

Past & Present Health History

Last Name _____ First Name _____ Middle Initial _____ Date of birth. _____
Address _____ Home Ph. _____
Work Ph. _____ Cell Ph. _____
E-Mail: _____ Preferred method of contact? (Circle one) Home / Work / Cell / Email Do we
have permission to leave a message at your preferred contact? Yes___ No___ Height_____ Weight_____
Pharmacy name and number _____ Occupation _____
Emergency Contact: _____ Phone: _____
Currently under care of a physician: yes no Name of physician _____

Do you now, or have you had in the past: (Check Y for yes or N for No)

YES/NO

YES/NO

- 1. ___ ___ History of heart problems, chest pain or stroke
- 2. ___ ___ Any chronic illness or condition.
- 3. ___ ___ Recent surgery (last 12 months)
- 4. ___ ___ High blood pressure
- 5. ___ ___ Pregnancy (now or within the last 3 months)
- 6. ___ ___ History of breathing or lung problems
- 7. ___ ___ Muscle, joint, or back disorder, or any previous injury still affecting you
- 8. ___ ___ Diabetes
- 9. ___ ___ Thyroid condition
- 10. ___ ___ Obesity (more than 20% over ideal body weight)
- 11. ___ ___ Increased cholesterol.
- 12. ___ ___ History of heart problems in immediate family
- 13. ___ ___ Arthritis
- 14. ___ ___ Bursitis
- 15. ___ ___ Muscle tension
- 16. ___ ___ Fatigue

- 17. ___ ___ Anxiety
- 18. ___ ___ Depression
- 19. ___ ___ Tanning within the last 30 days
- 20. ___ ___ Epilepsy
- 21. ___ ___ Keloid Formations
- 22. ___ ___ Open sores
- 23. ___ ___ Cold sores
- 24. ___ ___ Herpes
- 25. ___ ___ Fever blisters
- 26. ___ ___ Skin cancer
- 27. ___ ___ Sensitive Skin
- 28. ___ ___ Radiotherapy or chemotherapy in past 3 months
- 29. ___ ___ Do you Smoke? If so, How many a day _____
- 30. ___ ___ Drink Alcohol? If so, How often? _____
- 31. ___ ___ Hepatitis

Please explain any YES answers or other concerns:

Have you had any previous surgeries? If so please list all surgeries and dates performed:

List all physicians you have seen in the last 6 months:

List medications you are currently taking or have taken in the past 6 months:

Please list any drug allergies:

Please list any other known allergies (LATEX):

List any procedures you have had at a Spa or Medical Spa and negative results, if any:

I understand that the staff employed at the facility is not qualified to make medical assessments of my health and it is my responsibility to check with my physician before starting any treatment program.

Signed: _____

Date: _____

R.N./Physician _____