CLARK
Institute for Aesthetics

Patient Health History

Name:_____ Date of Birth: ____/____/_____

Body area to discuss: _____

Timeframe for Scheduling Surgery: _____

Number of Children: _____ Ages of Children: _____

Any adverse reaction to Anesthesia? _____

Currently Taking Steroids, or within the past year? _____

Have you been exposed to, or have any infectious disease? _____

Have you had any significant weight change in the past year? _____

Have any major changes occurred in your family in the past year (death, divorce, illness, etc.)? If so, please explain. _____

Have you received psychological counseling in the past 5 years? _____

List Medications, Supplements or None:	Dose:	How Often Taken:

List Allergies (Drug, Tape, Food) or None:	Reaction:

List Surgeries (including cosmetic):	Date:

Do you currently have breast implants? ___Yes ___ No If yes, implant size: _____

Current bra size? _____

Most recent mammogram date and results: _____

Please indicate usage and frequency of the following:

Alcohol ___ (x per week) Tobacco ___ (x per day) Vaping ___ (x per day) Marijuana ___ (x per day)

Former smoker? ___Yes ___ No

Family History of:

___Bleeding disorder, Who? _____ ___Diabetes, Who? _____

___Stroke, Who? _____ ___Anesthesia reaction, Who? _____

___Heart Disease, Who? _____

___Cancer, What type and who? _____

Have you ever had any of the following conditions? Please indicate with a check mark.

___ Blood Clots	___Lung Disease	___Diabetes
___Easy Bruising/Bleeding	___Asthma	___Acid Reflux/Ulcer
___Multiple miscarriages	___Shortness of Breath	___Hernia
___Nose bleeds/Nose trauma	___Chronic Cough	___Nausea/Vomiting
___Anemia	___Cold Sores	___Change in Bowel Habits
___Blood in Urine	___Migraines	___Difficulty in Urination
___High Blood Pressure	___Seizures	___Thyroid Disease
___Heart disease/Stroke	___Nerve Damage	___Liver Disease
___Pacemaker	___Loss of Consciousness	___ Kidney Disease
___Heart Attack	___Swelling of Hands/Feet	___Joint Stiffness/Decreased Mobility
___Irregular Heart Beat	___Dry Eyes	___Chronic Pain
___Heart Murmur	___Blurred Vision	___Depression/Anxiety
___Mitral Valve Prolapse	___Cornea Problems	___Psychiatric Condition
Cancer/Type: _____		___Drug/Alcohol Abuse

Please list any conditions you have had not listed above: _____

_____

Today's Date: ___/____/_____ Patient's signature: _____