THE IRVINE INSTITUTE OF MEDICINE & COSMETIC SURGERY

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HEALTH HISTORY QUESTIONNAIRE

Name: ______________________________ Date: ____________________

Please circle the appropriate response if you have ever experienced any of the following
If you are not sure, please do not answer the question.

HEART/BLOOD VESSELS

Rheumatic Fever............................	Yes	No
Rheumatic Heart Disease...............	Yes	No
Heart Valve Damage......................	Yes	No
Heart Murmur................................	Yes	No
Congenital Heart Defect.................	Yes	No
Artificial Heart Valve.....................	Yes	No
Prolapsed Heart Valve....................	Yes	No
High Blood Pressure………………	Yes	No
Heart Attack (Date________) …...	Yes	No
TIA/Stroke (Date________)……..	Yes	No
Heart Surgery (Date________) …..	Yes	No
Vascular Surgery (Date________) .	Yes	No
Pacemaker……………………..….	Yes	No
Coronary Heart Disease………..…	Yes	No
Congestive Heart Failure………....	Yes	No
Angina Pectoris/Chest Pain……....	Yes	No
Irregular/Rapid Heart Beats…..…..	Yes	No
Other:____________________		

BLOOD

Blood Clots or Thrombosis..........	Yes	No
Anemia...		
Sickle Cell Disease/Trait………...	Yes	No
Hemophilia..................................	Yes	No
Transfusion (Date________).......	Yes	No
Bruise easily for no reason………	Yes	No
Other: ____________________		

NERVOUS SYSTEM

Epilepsy………………………….	Yes	No
Seizure Disorder…………………	Yes	No
Multiple Sclerosis……………….	Yes	No
Chronic Pain…………………….	Yes	No
Anxiety/Depression……………..	Yes	No
Alzheimer's Disease/Dementia…	Yes	No
Psychiatric Treatment…………...	Yes	No
Psychological Counseling……….	Yes	No
Persistent Dizziness/Fainting……	Yes	No
Persistent Numbness/Tingling…..	Yes	No
Other: ____________________		

MUSCULOSKELETAL/ CONNECTIVE TISSUE

Arthritis………………………..….	Yes	No
Artificial Joint ………………..…..	Yes	No
Myalgia………………………..….	Yes	No
Chronic Back Pain…………..……	Yes	No
Other: ____________________		

RESPIRATORY

Tuberculosis (TB)…………..…….	Yes	No
Asthma………………………….....	Yes	No
Chronic Bronchitis…………..……	Yes	No
Emphysema…………….………..	Yes	No
Persistent Cough……………..…..	Yes	No
Cough Up Bloody Sputum…..……	Yes	No
Shortness of Breath……….……..	Yes	No
Sleep Apnea...................................	Yes	No
Other: ____________________		

URINARY TRACT

Kidney Disease..............................	Yes	No
Renal Dialysis................................	Yes	No
Venereal Disease............................	Yes	No
Sexually Transmitted Disease.........	Yes	No
Other: ____________________		

HEAD AND NECK

Glaucoma………………………..	Yes	No
Chronic Sinusitis………………...	Yes	No
Injury to Head or Neck................	Yes	No
Migraines.....................................	Yes	No
Unexplained Visual Change…….	Yes	No
Frequent or Severe Nosebleeds…	Yes	No
Persistent Sore Throat or Hoarseness……………………	Yes	No
Recurrent Neck Pain…...............	Yes	No
Difficulty Swallowing…………..	Yes	No
Lymph Node Swelling…………..	Yes	No
Other: ____________________		

FAMILY HISTORY

Has anyone in your family ever had:

(grandparent, parent, sibling, child)

Diabetes...	Yes	No
Heart Disease.......................................	Yes	No
Depression or Anxiety.........................	Yes	No
Tuberculosis...	Yes	No
Any disorder that "runs in" your family? …………………………….........	Yes	No
If yes, what type ________________		

WOMEN ONLY

Are you taking birth control pills?	Yes	No
Are you pregnant or a possibility that you may be pregnant?	Yes	No
If yes, due date? ________________		
Are you breast feeding?	Yes	No
Are you in Menopause or have you passed through Menopause?	Yes	No
Irregular Menstrual Cycle?	Yes	No
Dysmenorrhea……………………...........	Yes	No
Mood Changes……………………..........	Yes	No
Estrogen Replacement……….….........	Yes	No

MEN ONLY

Decreased Libido/ Sex Drive……........	Yes	No
Erectile Dysfunction/ Soft Shaft..........	Yes	No
Loss of Interest in Sex………..........	Yes	No
Decreased Energy Levels……...........	Yes	No
Decreased Muscle Strength…………...	Yes	No
Decreased Muscle Mass……….….......	Yes	No
Incomplete Orgasm with Sex……........	Yes	No
Low Testosterone Levels………..........	Yes	No

VACCINATIONS

Received primary series as a child? ..…	Yes	No
Last Tetanus-Pertusis over 5 years ago?	Yes	No
Last Flu Vaccine (Date________)		
Meningitis Vaccine……………..........	Yes	No
Frequent Travel to Third World Countries?	Yes	No

Please continue on back page →

Hepatitis.. Yes No	Cancer.. Yes No	Suppressed Immune System.................. Yes No
Cirrhosis of Liver/Liver Disease.… Yes No	If yes, what type _____________	Persistent Fever...................................... Yes No
Ulcers.. Yes No	Leukemia...................................... Yes No	Taken Steroid/Prednisone....................... Yes No
Jaundice... Yes No	Benign Tumors/Growths.............. Yes No	Taken Prescription Diet Pills................. Yes No
Frequent Heartburn or Reflux......... Yes No	**Type of Treatment:**	If yes, please check type: Yes No
Frequent Nausea/Vomiting............. Yes No	Surgery.. Yes No	Pondimin _____ Phen-fen _____
Rectal Bleeding……………….…. Yes No	Radiation Therapy......................... Yes No	Redux _____ Other:________
Abdominal Pain…………………..… Yes No	Chemotherapy............................... Yes No	Used Tobacco Products……………… Yes No
Other: ______________________	Hormone Therapy......................... Yes No	If yes, what type? ________________
		How much? _____________________
ENDOCRINE	**ALLERGY HISTORY**	How long? ______________________
Diabetes……………………………..….. Yes No	Are you allergic to or ever had a bad reaction to any of the following?	Still using tobacco? .... Yes No
Thyroid Disease………………….. Yes No		Would you like to quit? .... Yes No
Osteoporosis or Osteopenia………. Yes No	Lidocaine...................................... Yes No	Used Methamphetamine, Amphetamines or “Speed”? ……........... Yes No
Other: ______________________	Iodine…………………………… Yes No	Used Intravenous Drugs? …………… Yes No
	Penicillin...................................... Yes No	Used Cocaine or “Crack”? ……………. Yes No
	Sulfa Drugs.................................. Yes No	Used any other recreational drugs? ….... Yes No
	Other Antibiotics........................... Yes No	Drink alcoholic beverages? .... Yes No
	Aspirin... Yes No	If yes, how much? ________________
	Latex Products.............................. Yes No	Used Alcoholic Steroids? .... Yes No
	Other:______________________	Are you a recovering alcoholic or have a history of substance abuse? .... Yes No

Any additional information the doctor should be aware of: ____

WHAT PROCEDURES ARE YOU INTERESTED IN?

Medical Aesthetic Services:

- ☐ Skin Analysis with the Visa Complexion Software
- ☐ Botox
- ☐ Dermal Fillers
- ☐ Painless Laser Hair Removal
- ☐ Laser Skin Resurfacing & Rejuvenation
- ☐ Silkpeel Microdermabrasion
- ☐ Chemical Peels
- ☐ Skin Care Products and Mineral Make-up
- ☐ Liposuction with Smartlipo
- ☐ Hair Restoration Surgery
- ☐ Fat Grafting
- ☐ PRP Therapy

Medical Wellness Services:

- ☐ Bio-identical Hormone Therapy
- ☐ Executive Physical
- ☐ HCG Medical Weight Loss Program
- ☐ Cardiac Assessment and Testing
- ☐ Genetic Disease Testing

I agree that all of the information on this form is answered to the best of my knowledge.

x____ ________________________

Patient's Signature **Date**