

**REJUVENATE!
HEALTH HISTORY**

Name: _____ Date: _____
Height: _____ Weight: _____

Family History:	How are you related:
Diabetes _____	_____
Breast Cancer _____	_____
Other Cancers (specify) _____	_____
Bleeding Problems _____	_____
Blood Clots _____	_____
Anesthesia Problems _____	_____

Patient History:
List your surgeries with approximate dates:

List of medications you take - include the dosage and number of times you take them day, including supplements:

List of medications you are allergic to: _____
Allergy to Latex or rubber products: Yes No
Do you have a smoking history? Yes No If yes, how much per day? _____
If you quit, how long ago? _____
Alcohol use? Yes No If yes, how much per week?

Do you have a history of any of the following? Include approximate year:

Skin problems _____	Blood clots _____	Chronic liver diseases _____
Eye problems _____	Bleeding disorders _____	Chronic kidney diseases _____
Dry eyes _____	Bruising _____	Urinary tract infections _____
Diseases of ears _____	Tuberculosis _____	Kidney stones _____
Diseases of nose _____	Spastic problems _____	Numbness _____
Diseases of throat _____	Gynecological problems _____	Headaches _____
Chronic dry mouth _____	Last PAP smear _____	Seizures _____
Thyroid disorders _____	Chronic nausea/vomiting _____	Epilepsy _____
Diabetes _____	Jaundice _____	Heart murmur _____
Rheumatic heart disease _____	Stomach problems or ulcers _____	Convulsions _____
High blood pressure _____	Cancer (type) _____	Angina _____
Heart attack _____	Hepatitis _____	Trouble breathing _____
Other heart disease _____	Anemia _____	Asthma _____
Emphysema _____	Bronchitis _____	Pneumonia _____
Breast disease _____	Unexplained fevers _____	First day of last menstrual _____
Constipation or diarrhea _____	Any other serious _____ period	
	or chronic	
	medical illness	

Patient Signature _____