

THE MALONEY CENTER

PERSONAL HISTORY

NAME: _____

Please list any medical problems or previous hospitalizations _____

Have you had any serious past illnesses? _____

Please list any accidents or injuries _____

Please list any past surgeries (including minor surgery or surgery as a child) _____

YES NO

___ ___ Do you have any allergies to medication? List medications _____

___ ___ Do you have any food, environmental, or latex allergies? List reactions _____

___ ___ Are you currently taking any drug or medications? How often? List (Include over the counter) _____

___ ___ Do you take vitamins or herbal products? List _____

___ ___ Do you drink more than 6 cups of coffee per day?

___ ___ Do you drink alcohol? How much? How often? _____

___ ___ Do you smoke? How much per day? _____

___ ___ Do you ever get cold sores or fever blisters? _____

___ ___ Do you have skin sensitivities, frequent rashes, or eczema?

___ ___ Have you ever taken Accutane?

___ ___ Do you have a skincare regimen you follow? Describe _____

___ ___ Have you ever received local anesthesia? (Novacaine)

___ ___ Did you have a reaction to anesthesia?

___ ___ Are you a past/present carrier of a contagious disease? Please specify _____

___ ___ Are you or could you be pregnant?

___ ___ Have you taken medicine such as Cortisone or steroid during the past year?

___ ___ Do you have a personal or family history of any bleeding or clotting abnormalities?

___ ___ Do you bleed for more than a half hour after a needle stick?

___ ___ Do you bleed a day or more after surgery or a tooth extraction?

___ ___ Do you bruise easily?

___ ___ Do you bruise without cause?

___ ___ Do you bruise larger than a half dollar?

___ ___ Do you bruise from injections?

DATE OF YOUR LAST PHYSICAL? _____ DATE OF MOST RECENT BLOODWORK _____

DATE OF YOUR LAST CHEST X-RAY _____ HAVE YOU HAD AN ABNORMAL CHEST

X-RAY? _____ DATE OF LAST EKG _____ HAVE YOU HAD AN ABNORMAL EKG _____

FAMILY PHYSICIAN _____ PHONE# _____

SPECIALTY _____

NAME: _____

DO YOU HAVE OR HAVE YOU EVER HAD:

YES NO

- _____ Heart disease or heart trouble
- _____ High blood pressure
- _____ Lung disease
- _____ Hay fever
- _____ Kidney disease
- _____ Liver disease
- _____ Epilepsy/seizures/neurological problems
- _____ Thyroid or goiter problems
- _____ Chest pain
- _____ Chronic cough
- _____ Recent respiratory infection
- _____ Skin trouble/infections/rashes/irritations
- _____ Keloid or ugly scars
- _____ Glaucoma
- _____ Phlebitis
- _____ Problems lying flat
- _____ Nosebleeds
- _____ Fainting
- _____ Asthma
- _____ Have you considered seeing a psychologist/
therapist
- _____ Are you seeing a therapist now?
- _____ Are you on a special diet?
- _____ Recent weight loss (amount) _____
- _____ Any exposure to a communicable disease in the last 3 weeks? Explain _____

YES NO

- _____ Mitral valve prolapse
- _____ Diabetes
- _____ Muscle weakness
- _____ Difficulty urinating
- _____ Jaundice
- _____ Headache or dizzy spells
- _____ Bowel/colon disease or problems
- _____ Shortness of breath
- _____ Back or neck trouble
- _____ Ulcers/stomach trouble
- _____ Do you use eye drops?
- _____ Treatment of genital area
- _____ Are you easily depressed
- _____ Hiatal hernia
- _____ Blood transfusion
- _____ Ankle swelling
- _____ Facial fractures
- _____ Anemia
- _____ Drug or alcohol dependency
- _____ Height
- _____ Weight

DO YOU HAVE ANY OF THE FOLLOWING: Dentures _____ Partial plate _____ Bridgework _____

ARE YOU WEARING ANY OF THE FOLLOWING: Contacts _____ False eyelashes _____ Hearing aid _____
Wig/hairpece _____ Permanent eyeliner or other
Permanent cosmetics _____

FAMILY HISTORY: Diabetes _____ Bleeding _____ Heart disease _____ Anesthesia problems _____
Other _____

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR HEALTH? _____

Signed _____
(Patient or Guardian)

THE REQUESTED PERSONAL INFORMATION IS A NECESSARY PART OF OUR EVALUATION. ALL INFORMATION GIVEN TO US IS CONFIDENTIAL.