THE WESTON CENTER FOR AESTHETIC MEDICINE AND SURGERY

(954) 526-0066

Health Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: _____ Reason for Visit: _____

Age: _____ Height: _____ Feet _____ Inches Weight: _____ Lbs.

Current Physician(s): _____

List all Surgeries (Hospitalization and the Date of Occurrence):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Aids / HIV	No ☐ Yes ☐	Epilepsy / Seizures	No ☐ Yes ☐	Kidney Problems	No ☐ Yes ☐
Arthritis	No ☐ Yes ☐	Facial Pain	No ☐ Yes ☐	Pneumonia	No ☐ Yes ☐
Asthma	No ☐ Yes ☐	Fever Blisters	No ☐ Yes ☐	Sinus Problems / Infections	No ☐ Yes ☐
Bronchitis	No ☐ Yes ☐	Goiter / Thyroid	No ☐ Yes ☐	Stroke	No ☐ Yes ☐
Cancer	No ☐ Yes ☐	Hay Fever / Allergies	No ☐ Yes ☐	Tonsillitis	No ☐ Yes ☐
Depression	No ☐ Yes ☐	Headaches / Migraine	No ☐ Yes ☐	Tuberculosis	No ☐ Yes ☐
Diabetics	No ☐ Yes ☐	Heart Trouble	No ☐ Yes ☐	Ulcers	No ☐ Yes ☐
Dizziness / Vertigo	No ☐ Yes ☐	Hepatitis	No ☐ Yes ☐		
Ear Infection	No ☐ Yes ☐	High Blood Pressure	No ☐ Yes ☐		

Do you smoke? No ☐ Yes ☐ If yes, how much? _____ Pack(s)/day How long? _____ Years

Do you drink alcohol? No ☐ Yes ☐ If yes, how much? _____ How often? _____

Do you use recreational drugs? No ☐ Yes ☐ If yes, describe: _____

Do you have bleeding or bruising problems? No ☐ Yes ☐ If yes, describe: _____

Do you have problems with scarring? No ☐ Yes ☐ If yes, describe: _____

Do you have any history of problems with anesthesia? No ☐ Yes ☐ If yes, describe: _____

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

List ALL drug and/or latex allergies.

The above information is accurate and complete to the best of my knowledge.

Signature _____ **Date** _____