

Medical Evaluation Form

Name			Date	
Age_		Gender <u>M / F</u> Height Wei	ght	
*A11	ergie	S—list both drug & environmental (penicillin, local anesthetic	, topical products or LATEX)	
1. Pi	ease de	scribe your reasons for seeking consultation:	Office Use Only: Notes	
2. м	edical I	History:		
yes	no	Skin Disorders: (rashes, burns, scars, cancers) If yes, please describe		
yes	no	Eyes, Ears (cataracts, glaucoma, tinnitus, hearing impaired, dizziness) If yes, please describe		
yes	no	Throat (strep throat, difficulties swallowing) If yes, please describe		
yes	no	Nose (allergies, snoring, sinus infections) If yes, please describe		
yes	no	Lungs (asthma, emphysema, bronchitis, shortness of breath) If yes, please describe		
yes	no	Heart (MVP, irregularities, angina, high blood pressure, chest pain) If yes, please describe		
yes	no	Digestive (indigestion, reflux, ulcers, colitis) If yes, please describe		
yes	no	Breasts (cysts, pain, nipple discharge, cancer) If yes, please describe		
yes	no	Pelvic (fibroid, ovarian cysts, cancer) If yes, please describe		
yes	no	Menstrual Cycle (regular, irregular, degree of cramps, rate of flow) If yes, please describe		
yes	no	Urinary (bladder infections, bladder control, blood in urine) If yes, please describe		
yes	no	Neurological (headaches, neck, back or extremity pain/tremors, seizures) If yes, please describe		
yes	no	Endocrine (diabetes, hyper/hypothyroidism) If yes, please describe		
yes	no	Mental Status (anxiety, depression, eating disorder) If yes, please describe		

yes	no Bleeding disorders (frequent bruising, abnormal bleeding) If yes, please describe					Office Use Only: Notes
yes	no	Immune (HIV, Her	Ivotes			
		If yes, please desc				
yes	no	Other				
		If yes, please descri				
3. N	Medicatio	ons:				
List a Inclu	all prescri de herbs	ption, over the coun , vitamins and aspiri				
		Ме	dication	Daily Dosage]	
	1					
	2					
	2					
	4					
	5					
Ī						
	6				I	
4. s	Surgery:					
List a	all surger	ies with date and an	y complications:			
Г			, <u> </u>			
		Surgery		Date	Complications	
	1					
	2					
	2				I	<u></u>
5. V	What typ					
6 . I	Oo you si	noke? (what and ho				
- -						
/. D	o you d	rink alcohol? (how t	requently)			
						-
8. V	What type	es of foods do you e	-			
"	•J P	3				
9. F	amily H	ealth History:				
List d	diseases (diabetes, heart disea	se, cancer etc.)			
Sib	lings or	your children	Maternal Side		Paternal Side	1

			Office Use Only:
			Notes
	<u> </u>		<u> </u>
10. Make a list of the variou (e.g., prevention of disease, ag			
(e.g., prevention of disease, ag			
11. Current Skin Care Regin			
			- -
	completely reviewed the above	pages/information for	
completeness and/or changes	•		
Date:			
Signature:			
Office : I certify the supplied i			
Date:			
Date.			-
Signature:			