Anna Avaliani MD

Cosmetic & Laser Surgery

Medical History Form

Today's Date_____

Last Name:_____ First Name:_____ Middle:_____

Date of Birth: _____ Age:_____SEX:(M)____(F)_____ Height_____ Weight_____

Current Address:_____Apt: _____

City_____ State:_____ ZipCode_____

Cell Phone:_____ Email:_____

Occupation_____ Single____Married____ In a relationship_____Other_____

How wold you prefer to be contacted? Email_____ Cell Phone_____ No preference_____

How did you hear about us?_____

Would you like to be informed about our office specials? Yes_____ No_____

Medical History

Do you have any Drug allergies?

If Yes, Please list them:_____

Past Surgical History: (Name and date)_____

Do you have any of the following conditions? (Check Yes or No)

High Blood pressure	Y___N___	Prolonged Bleeding	Y___N___	Cold sores	Y___N___
High Cholesterol	Y___N___	Migraines	Y___N___	ALS	Y___N___
Heart Disease	Y___N___	Smoke	Y___N___	Myasthenia graves	Y___N___
Diabetes	Y___N___	Take blood thinners	Y___N___	Lambert Eaton Syndrome	Y___N___
Anxiety	Y___N___	Depression	Y___N___	HIV/AIDS	Y___N___
Hepatitis	Y___N___	Lupus/Scleroderma	Y___N___	Low/High Thyroid	Y___N___

Are you taking any medications? Please include over the counter medications, vitamins, supplements

_____

_____

Women ONLY:

Are you currently pregnant? Y____N_____ Please Initial:_____

What is the date of your last menstrual period?_____

Consultation

What products do you use for skin care, if any?_____

What procedure(s) are you interested today? _____

What procedures/treatments have you had or tried in the past?_____

_____

Were you satisfied with the results? Yes___/No____Why_____

Signature:_____ Date:_____

Thank you for taking time to fill out this form!

Reveal the best you