AESTHETIC CONCEPTS

Health History

Are you under a physician's care for a particular condition? Yes/No

If so, what?____

Have you had any serious illness, operations, or hospitiializations? Yes/No

If yes, describe: ____

Do you smoke?________# of packs per day________# of Yrs. smoking?____________________

Please Circle / Are you: Pregnant, Nursing a child, Planning a pregnancy

Do you have other health problems Dr. Morris should be aware of?__________________________

Please circle if you've ever had any of the following:

Heart Attack/Heart Surgery
Pacemake
Epilepsy or Seizure
Bells Palsy
High Blood Pressure
Mitral Valve Prolapse
Asthma / Bronchitis/Emphyzema
Pneumonia
Heart Murmur
Clotting Disorder
Glaucoma
Acne
Skin Disease
Skin Cancer
Implants-Breasts, hip, joints, etc.
Liposuction/Mesotherapy

Stomach Ulcers
Thyroid Problems
Prior Blood Transfusion
Abnormal Bleeding
Cold Sores / Herpes
Congenital Heart Disease
Kidney Disease
Diabetes
Depression / Mental Illness
Scleroderma/Lupus
Keloid Scarring
Alcohol/ Drug Dependence
RECENT TAN/SUNBURN
Stroke
Bruise Easily
Permanent Make Up

OFFICE NOTES:

MEDICATIONS:

Please list all allergies: ____

Please list all medications & herbal supplements: ____________________________________

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I certify that I have read and understand the questions above and that the above information is current and correct. I will not hold my doctor, Daniel K. Morris, DO, or any of his staff responsible for any errors or ommissions that I have made in completion of this form.

Patient / Legal Guardian Signature ____________________________**Date** __________________