RAVAL FACIAL AESTHETICS and ENT, P.C.

Patient Health History Form

In order for us to obtain a comprehensive medical history, it is important for you to fill out this form completely.

Today's Date_____ **Full Name**_____ **DOB:**_____

Please circle the following concerns that apply to you.

Aging Face Nasal Shape Wrinkles Sunspots Volume Loss Hair Loss Eye Lids Chin Shape

Other not listed above _____

Have you ever been diagnosed with any major medical problem? **YES** ☐ **NO** ☐

Medical Condition	*Year Diagnosed*

Have you had any previous surgeries either medical or cosmetic? YES ☐ **NO** ☐

Type of Surgery	*Date of Surgery*

Are you taking ANY kind of medication now? (This includes rx, over the counter, herbal) YES ☐ **NO** ☐

Medication Name	*Dosage*

ALLERGIES: Please list all allergies whether medication, food, or environmental

Allergy	*Type of reaction*

Do you use tobacco? Yes ☐ No ☐ If yes what type? _____ How Often_____

Do you consume alcohol? Yes ☐ No ☐ If yes what type? _____ How Often_____

Do you use recreational drugs? Yes ☐ No ☐ If yes what type? _____ How Often_____

Review of Systems: Have you had any problems recently in the following areas. (Circle all that apply)

Head/Neck Eyes Ears Nose/Sinus Mouth/Throat Heart Lungs/Respiratory Digestive

Female Health Bone/Joint Skin Brain Mental Blood Allergies Hormone

Explain: _____

_____

_____

(Women only) Are you pregnant? Yes ☐ No ☐

I certify that all the information is accurate.

_____

Patient Signature