Health Questionnaire

Name: ____DOB: ______________ Date: ____________________

Sex: M F Occupation: __________________________Referring MD: _________________________________

What is the reason for your visit today? ____

Current Medications:____

Allergies to Medications: _______________________________Other Allergies: __________________________

Pharmacy Name/Phone Number: ____

General Medical History

		Details
Do you have any medical problems?	□Yes □ No	
If you answered "yes" to above, do you have, or have you ever had:		
Abdominal bleeding	□Yes □ No	
Asthma	□Yes □ No	
Bleeding disorder	□Yes □ No	
Cancer	□Yes □ No	
Cataracts	□Yes □ No	
Chest pain/tightness	□Yes □ No	
Depression	□Yes □ No	
Diabetes	□Yes □ No	
Gynecologic disorder	□Yes □ No	
Heart disease	□Yes □ No	
Heart murmur	□Yes □ No	
Heart valve repair/replacement	□Yes □ No	
Hepatitis	□Yes □ No	
High blood pressure	□Yes □ No	
Hip or join replacement	□Yes □ No	
Kidney stones or renal disease	□Yes □ No	
Pacemaker or Defibrillator	□Yes □ No	
Stroke	□Yes □ No	
Thyroid disorder	□Yes □ No	
Tuberculosis	□Yes □ No	
Ulcers	□Yes □ No	
Other	□Yes □ No	

SOMA™ SKIN & LASER

Skin History

		Details
Do you have, or have you ever had:		
History of severe sunburn	□Yes □ No	
Eczema	□Yes □ No	
Hives	□Yes □ No	
Skin Cancer	□Yes □ No	
Actinic keratosis	□Yes □ No	
Atypical moles	□Yes □ No	
Herpes simplex	□Yes □ No	
Lupus	□Yes □ No	
Sarcoid	□Yes □ No	
Acne	□Yes □ No	
Psoriasis	□Yes □ No	
Other	□Yes □ No	

Surgery History

Surgery/Hospitalization	*Date*	*Anesthesia complications*	*Notes*

Do any of your family members have:

		Family member	**Notes**
Abnormal bleeding or clotting	□Yes □ No		
Anesthesia problems	□Yes □ No		
Autoimmune problems	□Yes □ No		
Cancer	□Yes □ No		
Drug allergies	□Yes □ No		
Skin cancer	□Yes □ No		
Acne	□Yes □ No		
Atypical moles	□Yes □ No		
Eczema	□Yes □ No		
Lupus	□Yes □ No		
Psoriasis	□Yes □ No		
Sarcoid	□Yes □ No		
Other	□Yes □ No		

Health Habits:

Do you smoke? Y N Quit. If yes, number of packs/day? _______

Do you drink alcohol? Y N If yes, how many drinks/day? _________

Do you use any illegal drugs? Y N If yes, which drugs? _____________

Do you spend long hours in the sun? Y N

For Females only:

Pregnant or Nursing? Y N

Trying to become pregnant? Y N