

Personal Health History

2021



Please complete this form to the best of your ability.
If you have any questions, please talk to the nurse when you are called to the back.

Last Name: _____ First Name: _____ Middle Name: _____

Date Of Birth: (Month/Day/Year) _____ Prefers to be Called: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Would you like to receive Courtesy Appointment Reminders via e-mail?	Yes	No
Would you like to receive our newsletter and current news via e-mail?	Yes	No

For your safety, we request that you provide the contact information of a relative, friend, or guardian whom you give consent to the staff at the Nakatsui DermaSurgery to contact in the case of an emergency or in a situation where we are attempting to reach you with urgent results, but we are not able to get in contact with you. We may divulge limited personal medical information to this contact person should we feel that it is necessary.

Name: _____ Relation to you: _____

Phone Number: _____ Alternate Phone Number: _____

How did you hear about our clinic?: _____

Did a physician refer you to our clinic for today's visit?	Yes	No
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If Yes, please indicate the name of the physician: _____

Are you a smoker within the past year?	Yes	No
Are you currently pregnant?	Yes	No
Are you a Canadian citizen?	Yes	No
Do you have any known ALLERGIES?	Yes	No

If YES, what are you allergic to? _____

Are you taking any **PRESCRIBED MEDICATIONS**, herbal products, and/or non-prescription drugs? Yes No

If YES, please list all: _____

Past anesthesia and surgical procedures (spelling not important): _____

Have you or any member of your family had any problems with anesthesia?	Yes	No
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If YES, please describe: _____

Have you had any problems with dental anesthetic (freezing)?	Yes	No
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If YES, please describe: _____

Height: _____ Weight: _____

Have you ever had any of the following:

	Yes	No		Yes	No
Chemical Peels/ Dermabrasion			Botox/Fillers		
Laser Resurfacing			Face Lift		
Other Cosmetic Procedures			Liposuction		

If YES, please specify: _____

Do you currently have or have you ever experienced any of the following medical problems/treatments?:

	Yes	No		Yes	No
Pacemaker			HIV/AIDS		
Heart Attack			Herpes simplex or fever blisters		
Other heart disease			Cancer		
High Blood Pressure			Skin Cancer		
Blood clots			Rheumatic disease		
Blood disorders			Rheumatoid Arthritis "Gold" Therapy		
Chest pain			Diabetes Type I / Type II		
Stroke			Lupus or other auto-immune deficiency		
Blood thinning medications			Keloid or very thick scarring		
Asthma			Transplant Anti-Rejection Drugs		
Lung disease			Psoriasis		
Difficulty breathing			Vitiligo		
Sleep apnea or snoring			Leg ulcer		
Epilepsy or Seizures			Phlebitis		
Fainting spells			Anxiety disorders		
Kidney disease			Muscle disorders		
Hepatitis			Treatment with Accutane, Epuris, or		
Other Liver Disorders			Isotretinoin in the past 6 months		

Please provide details of the above and list any other medical conditions or impairments: _____

For safety reasons, should young children accompanying you become disruptive in the patient room for any appointment, please be aware that you may be asked to reschedule your appointment.

Also, please be aware that for safety reasons, please do not bring your children, family members (unless absolutely necessary), or friends into the LASER treatment rooms. Should you need to bring your children to the clinic for your laser appointment without another responsible person with them, please be aware they will need to remain in the waiting area and that Nakatsui DermaSurgery and staff shall not be responsible for them.

We sincerely thank you for your attention and understanding to the above.

Please confirm this information is accurate to the best of your knowledge (Patient/Parent if under the age of 18/Legal Guardian) by signing below. If filling out electronically, you will be able to sign this at your visit

Signature

Print Name

Date _____