Personal Health History 2024

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: _____ Personal Health #:_____

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 ☐
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 ☐
If YES, please describe:
_____
Have you had any problems with dental anesthetic (freezing)? Yes ☐ No ☐
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 Blood	☐	☐	Skin Cancer	☐	☐
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 Isotretinoin in the past 6 months	☐	☐
Other Liver Disorders _____					

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

_____

_____

For health and safety, I agree to go to a laboratory for blood testing if any NDS team member is involved in a needlestick injury related to my treatment.

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 _____