Celine Aesthetic Medicine & Laser Lipoplasty - (518) 348-1940

Medical History Form

Patient's Name: _____ DOB: _____

Address: _____

Street City State Zip Code

Phone: Home: _____ Work: _____ Cell: _____

E-mail address: _____

Emergency Contact Name: _____ Relationship: _____

Phone: Home: _____ Work: _____ Cell: _____

Current Height: _____ ft. _____ in. Current Weight: _____ lbs.

At what weight would you feel comfortable to maintain? _____ lbs.

Please list any allergies (include medications such as Lidocaine, Antibiotics, Sulfa, etc.)

_____

Current Medications:

_____

General Medical History

Have you ever been hospitalized? YES NO If yes, please explain below

Year diagnosis Reason for hospitalization Description/outcome

_____

_____

_____

_____

Please use the space below to describe any present or past medical problems

Problem	Y/N	Year Diagnosed	Description
High Blood Pressure	Y/N	_____	_____
Diabetes	Y/N	_____	_____
Thyroid Problems	Y/N	_____	_____
Heart Disease	Y/N	_____	_____
Lung Disease	Y/N	_____	_____
Kidney Disease	Y/N	_____	_____
Liver Disease	Y/N	_____	_____
Arthritis	Y/N	_____	_____
Cancer	Y/N	_____	_____
Stroke/Gout	Y/N	_____	_____
Ulcers	Y/N	_____	_____
Gallstones	Y/N	_____	_____
Back Problems	Y/N	_____	_____
High Blood Cholesterol	Y/N	_____	_____
Seizures/Epilepsy	Y/N	_____	_____

Do you? Smoke Y/N Drink alcohol? Y/N Amount per day _____

_____ _____

Patient's Signature Today's Date