BODY by DESIGN
a Medical Spa

New Patient H & P

Patient Name _____ *S.S.N.* _____

Have you consulted any other doctors about this? *No* ____ *Yes* ____

If Yes, please list their names: _____

General Health: *Good* ____ *Fair* ____ *Poor* ____

If not "Good", please explain:

_____

_____

Height _____ *Weight* _____ *Recent Weight Change* _____ *lbs.* *Loss* ____ *Gain* ____

Allergies *No* ____ *Yes* ____

If Yes, (Please list:)

_____ _____ _____

_____ _____ _____

Serious Illnesses (Please List)

Illness	*Year*	*Hospital*	*Physician*

Previous Surgery (Please List)

Operation	*Year*	*Hospital*	*Surgeon*	*Anesthetic*

Any complication or after effects from any of these operations? *No* ____ *Yes* ____

If yes, please explain: _____

What is your approximate daily consumption of:

Coffee or Tea _____ *Alcohol* _____ *Tobacco* _____ *Recreational Drugs* _____

Does anyone in your house smoke? _____

Please list ALL medications you take and the dosages, whether prescribed or over-the-counter (include Birth Control Pills, Diuretics / Water Pills, Heart and Blood Pressure Pills, Hormones, Nose Drops, Nasal Sprays, Blood Thinners, Aspirin, Rub-On Creams, Weight Reducing Pills, Tranquilizers, Laxatives, Vitamins, Etc.).

_____ _____ _____

_____ _____ _____

Signature _____ *Date* _____