



Anna Avaliani MD

Cosmetic & Laser Surgery

Medical History Form

Today's Date _____
Last Name: _____ First Name: _____ Middle: _____
Date of Birth: _____ Age: _____ SEX: (M) _____ (F) _____ Height _____ Weight _____
Current Address: _____ Apt: _____
City _____ State: _____ Zip Code _____
Cell Phone: _____ Email: _____
Occupation _____ Single _____ Married _____ In a relationship _____ Other _____
How would you prefer to be contacted? _____ Email _____ Cell Phone _____ No preference _____
How did you hear about us? _____
Would you like to be informed about our office specials? Yes _____ No _____

Medical History

Do you have any Drug allergies?

If Yes, Please list them: _____

Past Surgical History: (Name and date) _____

Do you have any of the following conditions? (Check Yes or No)

High Blood pressure	Y__N__	Prolonged Bleeding	Y__N__	Cold sores	Y__N__
High Cholesterol	Y__N__	Migraines	Y__N__	ALS	Y__N__
Heart Disease	Y__N__	Smoke	Y__N__	Myasthenia graves	Y__N__
Diabetes	Y__N__	Take blood thinners	Y__N__	Lambert Eaton Syndrome	Y__N__
Anxiety	Y__N__	Depression	Y__N__	HIV/AIDS	Y__N__
Hepatitis	Y__N__	Lupus/Scleroderma	Y__N__	Low/High Thyroid	Y__N__

Are you taking any medications? Please include over the counter medications, vitamins, supplements

Women ONLY:

Are you currently pregnant? Y__N__ Please Initial: _____

What is the date of your last menstrual period? _____

Consultation

What products do you use for skin care, if any? _____

What procedure(s) are you interested today? _____

What procedures/treatments have you had or tried in the past? _____

Were you satisfied with the results? Yes ___/No ___ Why _____

Signature: _____

Date: _____

Thank you for taking time to fill out this form!

