Date: _____

Account # _____

LAKESIDE
COSMETIC CENTER
CHELSEA OBOURN M.D.

MEDICAL HISTORY QUESTIONNAIRE

Please complete both sides of this form so we can provide you with the best of care

Patient Name: _____ DOB: / / Age: _____
Please Print Last First

Reason for Visit: _____ Gender: ___ Male ___ Female

Patient Home Phone Number: _____ Cell:_____

Occupation: _____ Patient Accompanied By: _____

PHARMACY INFORMATION:

Name: _____ Address:_____

Primary Care Provider: _____ Doctor who Sent you here: _____

PAST MEDICAL HISTORY

□ ADD
□ Anemia
□ Anesthesia Problems
□ Arthritis
□ Asthma
□ Birth History (ie Preemie, c-section, low birth weight)
_____
_____
□ Bleeding Disorders
□ Cancer (skin, thyroid, etc)
Type: _____
□ Depression/Anxiety
□ Diabetes, Type I or II
(Please circle I or II)
□ Dizziness
□ Environmental Allergies
□ Food Allergies
□ Gastric Reflux
□ Headaches
□ Hearing Loss
□ Heart Disease
□ High Blood Pressure
□ High Cholesterol
□ High Lipids
□ HIV
□ Hoarseness
□ Insomnia
□ Kidney Disease
□ Liver Disease
□ Lung Disease
□ Migraine Headaches
□ Nasal Obstruction
□ Restless Leg Syndrome
□ Sleep Apnea
□ Prior Sleep Study
When: _____
Where: _____
□ Sinusitis
□ Snoring
□ Stomach Ulcer
□ Strep Throat
□ Stroke
□ Thyroid Disease
□ TMJ Disorder
□ Tonsillitis

□ No Pertinent History □ Other: _____

PAST SURGICAL HISTORY

Please include dates of surgery

□ Ear Surgery _____ □ Neck Surgery (i.e. thyroid) _____ □ Vocal Cord Surgery _____
□ Facial Surgery _____ □ Skin Lesion/Cancer Surgery _____
□ Nasal/Sinus Surgery _____ □ Tonsillectomy/Adenoidectomy _____
□ Other _____

MEDICATION HISTORY

List current medications and dosage:

_____

_____

DRUG ALLERGIES

Drug Allergies: □ No Known Drug Allergies □ Yes (if yes, please list and include reaction)

_____

FAMILY MEDICAL HISTORY

□ Bleeding Disorders
□ Cancer
Type: _____
□ Family History Unknown
□ Diabetes
□ Environmental Allergies
□ Hearing Loss
□ Other: _____
□ Heart Disease
□ High Blood Pressure
□ Sleep Apnea
□ Thyroid Cancer
□ Thyroid Disease

SOCIAL HISTORY

Alcohol Usage	Tobacco Usage	Other
□ Currently Every Day	□ Currently Every Day	□ Do you live alone? (check for yes)
Amount: _____ Type: _____	Amount: _____ Type: _____	□ Prior or Current Recreational Drug Use
□ Currently Some Days	□ Currently Some Days	□ Other Risk Factors for HIV
Amount: _____ Type: _____	Amount: _____ Type: _____	Explain: _____
□ Former Age Quit: _____	□ Former Age Quit: ____	
□ Never	□ Never	

REVIEW OF SYSTEMS

Please check all symptoms which you have, or have had recently. If you have not experienced a medical problem under the symptom listed, check the NO Box.

CONSTITUTIONAL SYMPTOMS

□ fatigue □ fever □ difficulty sleeping
Other: _____
□ No Constitutional Symptoms

EYE SYMPTOMS

□ eye discomfort □ changes in vision
Other: _____
□ No Eye Symptoms

CARDIOVASACULAR SYMPTOMS

□ chest pain □ irregular heart beats
□ lightheadedness
Other: _____
□ No Cardiovascular Symptoms

PSYCHIATRIC SYMPTOMS

□ anxiety □ depression
Other: _____
□ No Psychiatric Symptoms

RESPIRATORY SYMPTOMS

□ shortness of breath □ hoarseness □ cough
□ wheezing
Other: _____
□ No Respiratory Symptoms

INTEGUMENT (SKIN) SYMPTOMS

□ new skin lesions □ lumps
□ change in mole appearance
Other: _____
□ No Integument (skin) Symptoms

ALLERGIC-IMMUNOLOGIC SYMPTOMS

□ environmental allergies □ immune deficiency
Other: _____
□ No Allergic-Immunological Symptoms

NEUROLOGICAL SYMPTOMS

□ speech difficulties □ migraines □ dizziness □ headaches
□ seizures □ numbness/tingling Other:
_____
□ No Neurologic Symptoms

MUSCULOSKELETAL SYMPTOMS

□ muscular weakness □ twitching □ gait changes
□ joint pain
Other: _____
□ No Musculoskeletal Symptoms

ENDOCRINE SYMPTOMS

□ weight gain □ weight loss □ history of thyroid problems
□ hot or cold intolerances
Other: _____
□ No Endocrine Symptoms

GASTROINTESTINAL SYMPTOMS

□ nausea □ heartburn □ difficulty swallowing
□ choking on liquids □ reflux
Other: _____
□ No Gastrointestinal Symptoms

HEME (BLOOD) – LYMPH SYMPTOMS

□ swollen lymph nodes □ easy bleeding or bruising
Other: _____
□ No Hemo(blood)-Lymph Symptoms

OTHER PERTINANT INFORMATION WE SHOULD KNOW