4914 Bissonnet Street, Suite 100, Houston, TX 77401

PATIENT MEDICAL HISTORY FORM

Please print information clearly below. Let us know if you have any questions.

Appointment Date:			
Patient's Last Name:			First Name:
Birth Date:	Age:		Gender:
Height: Weight:		Physician name:	
Pharmacy phone #:			

Reason(s) for Consultation:

COSMETIC HISTORY (Please check any procedures that may apply to you):

	Face lift
	Eyelid lift
	Rhinoplasty
	Lips
	Fillers (name):
	Neuromodulators: (Botox, Dysport, Xeomin)
	Breast surgery

Have you had any complications from previous cosmetic surgeries or procedures?

MEDICAL HISTORY (Please check any medical conditions that may apply to you):

	Diabetes		Hernia repair
	High blood pressure		Heart disease
	Lung disease or asthma		Autoimmunedisorders (like Lupus)
	Anemia or blood disorders		Seizures
	Stroke		HIV infection
	Cancer within the last 5 years		Hepatitis
	Blood disorders		Psychiatric disorders
	Pacemaker or defibrillator		Metal plates, implants or devices
	Renal failure		History of radiation
	Abdominal or colon surgery		

Have you ever been diagnosed with an of the following skin conditions?

	Heat urticaria or hives		Diseases of the collagen
	Vitiligo		Herpes/cold sores/fever blisters
	Eczema		Skin cancer
	Psoriasis		Sensitivity or allergy to the sun
	Melasma		Abnormal scarring

Current Medications (Prescription, Over the Counter, Vitamins & Supplements):

Drug Allergies:	Reactions:

Have you taken any of the following medications in last 6 months?

Doxycycline, Minocycline, Tetracycline	Blood thinners	Accutane® or similar pill

Have you smoked in the past year?	Yes	No
Do you use any other tobacco products:	Yes	No
Do you drink alcoholic beverages? How often? Daily Weekly Monthly Weekends only	Yes	No
Have you used any tanning beds, lamps or products in the last 6 weeks?	Yes	No
Do you have any permanent make-up or tattoos in area to be treated?	Yes	No

WOMEN ONLY:

Are you pregnant or nursing?	Yes	No
Do you have a history or Polycystic Ovarian Syndrome?	Yes	No

If there is any other important information about your health we need to know, please use space below:

Person(s) authorized to discuss my protected medical information and receive copies of my medical history and records are:

Authorized Name Relationship Date

I certify that the information provided on this medical history is correct and complete. Further, I understand that providing incomplete and incorrect information may not only jeopardize my health, but also render ineffective or harmful, any treatment I receive from Dr. Suneel Chilukuri.

Signature: ______________________ Date: ______________

Thank you for completing your medical history form.