The Edge For Men

Health Questionnaire

Patient Name_____

Date of Birth_____

Rate your general heath

Excellent	Good	Fair	Poor

List your medical and past surgical history.

_____

_____

_____

List all prescription and over the counter medications and supplements you take.

_____

_____

_____

Please list all drug allergies and/or problems with anesthesia.

_____

Please list any prior cosmetic or aesthetic procedures you have had. (surgery, Botox, fillers, laser treatments, etc)

_____

_____

Have you had any invasive or ablative procedures in the past 3 months? ☐Y ☐N

Please describe _____

Do you have any metal plates and/or screws? ☐Y ☐N

Please describe _____

How would you describe your consumption of alcohol?

Never	1-3 drinks/wk	5-10 drinks/wk	10+ drinks/wk

Do you smoke or chew tobacco products? ☐Y ☐N

If so, how much and number of years _____

Please turn over and complete the back of this sheet

Do you have, or have you had, any of the following diseases or problems?

- Rheumatic fever or rheumatic heart disease, disorders, anemia, easy bruising, clotting disorders, bleeding ..... ☐ Y ☐ N
- Congenital heart disease or valve problems ..... ☐ Y ☐ N
- High cholesterol or lipid disorder..... ☐ Y ☐ N
- Implanted electronic device, internal defibrillator or brain stimulation device ..... ☐ Y ☐ N
- Heart Disease - arrhythmia, heart attack, coronary insufficiency, stroke..... ☐ Y ☐ N
- History of cancer of any kind ..... ☐ Y ☐ N
- High blood pressure ..... ☐ Y ☐ N
- Shortness of breath, asthma, hay fever or chronic sinus problems ..... ☐ Y ☐ N
- Hives, skin rash, or fever blister..... ☐ Y ☐ N
- History of light headedness or fainting ..... ☐ Y ☐ N
- History of seizures, neurological or psychiatric problems..... ☐ Y ☐ N
- History of scarring or keloid formation..... ☐ Y ☐ N
- Diabetes ..... ☐ Y ☐ N
- Hepatitis or other liver disease..... ☐ Y ☐ N
- Arthritis or inflammatory disorders including lupus ..... ☐ Y ☐ N
- Stomach ulcers..... ☐ Y ☐ N
- Chronic infection including hepatitis, HIV..... ☐ Y ☐ N
- Kidney trouble ..... ☐ Y ☐ N
- History of cold sores, lip blisters, oral herpes..... ☐ Y ☐ N
- Tuberculosis ..... ☐ Y ☐ N
- Do you have a persistent cough or cough up blood at any time ..... ☐ Y ☐ N
- Skin – active sores, psoriasis, eczema, rash, acne, light allergy ..... ☐ Y ☐ N
- Low blood pressure ..... ☐ Y ☐ N
- Sexually transmitted diseases including Herpes outbreaks ..... ☐ Y ☐ N
- Chronic viral infection ..... ☐ Y ☐ N
- Personal or family history of blood clots in legs or lungs, or leg swelling..... ☐ Y ☐ N
- Varicose veins or venous insufficiency ..... ☐ Y ☐ N
- Other _____

Please explain any items where you checked yes:

_____

_____

_____

_____

_____

_____

_____

I, MYSELF, HAVE FILLED OUT THIS HEALTH QUESTIONNAIRE COMPLETELY AND I HAVE NOTIFIED THE OFFICE OF ALL MY MEDICAL PROBLEMS.

Patient's Signature _____Date: ____/____/_____