The Edge For Men
Health Questionnaire

Patient Name_______________________________
Date of Birth_______________________________

Rate your general health, please circle

_____________ _____________ _____________ _____________

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, please circle.

_____________ _____________ _____________ ____________________

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 ______

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:

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

Patient's Signature ____Date: ____/____/_____