Forever Young, Inc.

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Please complete this form carefully. It is of considerable help in determining the state of your health and the way you may respond to surgery. **THIS MEDICAL HISTORY QUESTIONNAIRE IS PRIVATE AND CONFIDENTIAL AND IS FOR PHYSICIAN USE ONLY**.

NAME: _____ DATE: _____

MARITAL STATUS: ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOWED** ☐ **SEPARATED**

I. 1. Are you allergic or sensitive to any medications? ☐No ☐ Yes
If Yes, please list: _____

2. Are you allergic to Xylocaine or novocaine? ☐ No ☐ Yes
3. Have you ever been told that you bleed more than normal ☐ No ☐ Yes
4. Do you bruise easily: ☐ No ☐ Yes
5. Are you allergic or sensitive to tape? ☐ No ☐ Yes
If Yes: Itching? _____ Redness? _____
6. Have you ever had any general anesthetic? ☐ No ☐ Yes
If Yes, Were there any problems?
_____

II. 1. Are you now under treatment for any medical condition? _____
2. When did you last complete your last physical exam? _____ By Whom? _____
3. When was your last chest x-ray? _____
4. Have you ever had any serious or prolonged illness? ☐ No ☐ Yes
If Yes, what and when _____
5. List operations, serious injuries and accidents, giving dates and names of hospitals.
_____
Were there any complications from surgery, such as bleeding or infections?
_____
6. Ht? _____ Usual Weight? _____ Have you recently lost or gained any weight? _____

7. Do you use eye drops? ☐ No ☐ Yes
8. Do you take contraceptive pill? ☐ No ☐ Yes

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FAMILY HISTORY

III. Relation:	If Living Age:	State of Health	If Deceased Age:	Cause of Death
1. Father				
2. Mother				
3. Brothers				
4. Sisters				

IV. Has any blood relative (grandparent, parent, brother, sister, child, etc.)

	NO	YES	RELATIONSHIP
1. Had cancer?	☐	☐	
2. Had high blood pressure?	☐	☐	
3. Had heart disease?	☐	☐	
4. Had problem of excessive bleeding?	☐	☐	
5. Had diabetes?	☐	☐	

V.

1. Have you ever had any x-ray treatment to your head or neck? ☐ No ☐ Yes
2. Have you ever had thyroid trouble ☐ No ☐ Yes
3. Do you take Valium? ☐ No ☐ Yes How much?
4. Do you take sleeping pills? ☐ No ☐ Yes How much?
5. What medication or drugs are your currently taking?
6. Do you smoke? ☐ No ☐ Yes
   If Yes, ☐ Cigarettes ☐ Cigars ☐ Pipe How much?
7. Do you use Alcohol? ☐ No ☐ Yes If Yes, How much?

8. Have you ever had a serious or chronic condition of: If Yes, please give details.
   A. Eyes: ☐ No ☐ Yes:
   B. Nose, Throat or Mouth: ☐ No ☐ Yes:
   C. Breasts: ☐ No ☐ Yes:
   D. Heart & Blood vessels, including high blood pressure: ☐ No ☐ Yes:
   E. Lungs, including cough: ☐ No ☐ Yes:
9. Have you ever had hepatitis? ☐ No ☐ Yes
10. Have you ever had colitis, ulcers or gastritis? ☐ No ☐ Yes