Health Questionnaire

Windsor Medical Aesthetics

Briarwood COSMETIC SURGICAL CENTRE

Medical History	*Mark (c) for current problems. Check (✓) box and indicate your age when you had any of the following symptoms or diseases.*				
☐ Anemia	☐ Diabetes	☐ Immune Therapy	☐ Phlebitis	☐ Spider Veins	☐ Varicose Veins
☐ Asthma	☐ Digestive Difficulties	☐ Irregular Pulse	☐ Recent Weight Loss	**Women**	
☐ Autoimmune Disease	☐ Eaton Lambert Syndrome	☐ Migraine Headaches	☐ Seizures	Regular Menstrual Periods: Yes ☐ No☐	
☐ Bleeding Disorder	☐ Heart Problems	☐ Myasthenia Gravis	☐ Sleep Difficulties	Birth Control Method_____	
☐ Bruise Easily	☐ Herpes/Cold Sores	☐ Pacemaker/ Defibrillator	☐ Stroke	Children: Yes ☐ No☐	Breastfeeding: Yes ☐ No☐
☐ Cancer	☐ Hypertension	☐ Palpitations	☐ Thyroid Disease	Menopausal Symptoms: Yes ☐ No☐	

Non- Drug Allergies		Weight: _____	Height: _____	**Skin History**	
☐ Nickel	☐ Sun Sensitivity	Alcohol – OZ/Week____		☐ Abnormal Moles	☐ Fragile Skin
☐ Other: _____		Smoking - # Cigarettes/Day__ #Years__		☐ Acne	☐ Hives
Drug Allergies		**Skin Type**		☐ Accutane Use	☐ Rash
		☐ I (always burns)	☐ IV (olive)	☐ Eczema	☐ Skin Cancer
		☐ II (sometimes burns)	☐ V (asian)	☐ Excessive (Keloid) Scarring	
		☐ III (always tans)	☐ VI (black)	☐ Frequent Sun Exposure	

List *All* Medications (Including Over-the-Counter Medications and Herbal Remedies)	**Previous Cosmetic and Surgical Treatments**	**Other Health Issues**

NOTES (INTERNAL USE ONLY)