MEDICAL HISTORY FORM

Patient Name: ________________________________ **Date of Birth**: ________________________
Occupation:________________________________**Employer:**________________________________

REASON FOR VISIT:____

EMERGENCY CONTACT:______________________________**Relationship**___________________
Emergency Contact Phone:____

FAMILY HISTORY

Has any blood relative ever had the following? (Please indicate by circling the condition(s) w/ brief description.)

Breast Cancer_________________High blood pressure___________Kidney Disease____________
Melanoma/Skin Cancer__________Heart Disease________________Depression_______________
Blood Clots___________________Stroke______________________Diabetes_________________

PAST MEDICAL HISTORY

Have you ever had the following: (Please indicate by circling the condition(s) w/ brief description.)

Heart Disease___________________Cancer_____________________Stomach Ulcer____________
Arthritis_______________________Glaucoma___________________Kidney Disease____________
Rheumatic Fever________________Asthma_____________________Thyroid Disease____________
Anemia_________________________AIDS or HIV positive_________Stroke___________________
Tuberculosis____________________Abnormal Bleeding___________Diabetes_________________
Bladder infections_______________Hepatitis___________________Emphysema_______________
High Blood Pressure _____________Epilepsy____________________Other lung problems _______
Heart Murmur___________________Abnormal liver ______________Other__________________
MRSA________________________ Sleep Apnea_________________
Depression/Anxiety/Other Psychological Disorders____________________________

NAME OF PRIMARY CARE PHYSICIAN:____

LIST ANY PREVIOUS SURGERIES

Year	Procedure
__________________	____
__________________	____
__________________	____
__________________	____

ALLERGIES TO MEDICATIONS: (please list medication and reaction): _______________________
____
____

Movassaghi Plastic Surgery & Ziba Medical Spa
330 S. Garden Way, Suite 100 • Eugene, Oregon 97401

Revised 07/24/2012

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List all medications (including dosage) you are taking including non-prescription drugs, vitamins or herbals:
____
____
____

Are you currently taking Aspirin ☐ No ☐ Yes Reason: _____________

Are you taking Coumadin or other blood thinners? ☐ No ☐ Yes

Current Height: _______ Weight: ________ BMI: _______

REVIEW OF SYSTEMS (to be reviewed with the physician and/or assistant)

Do you have now or have you had within the past year: (Please indicate by circling the condition(s).

Weight Change	Swollen Feet/Ankles	Seizures
Dry Eyes	Skin Rash	Joint/Muscle Pain
Chronic Cough	Chronic Diarrhea	Jaundice
Swollen Lymph Nodes	Chest Pain	Easy Bleeding
Rapid Heart Beat	Easy Bruising	All Others Negative

FOR WOMEN ONLY

Currently pregnant ☐ No ☐ Yes Are you currently breast feeding ☐ No ☐ Yes

Number of pregnancies_______ Children_______

Are you planning future pregnancies ☐ No ☐ Yes If Yes, When:____________________________

Date of last mammogram __________

SOCIAL HABITS

	No	Yes	When Started	When Stopped	Amount
Tobacco Use					Packs per day
Coffee					Cups per day
Alcohol					Per week
Recreational Drugs					

EXERCISE

	No	Yes	Type of Exercise	Frequency (times per week)
Do you exercise?				

I verify that the above information is true and accurate to the best of my knowledge.

____________________________________ ________________________

Patient Signature (or parent if patient is a minor) Date