PERSONAL AND HEALTH HISTORY

Today's date:_____

Name:_____D.O.B.:_____Age:_____
Height:_____Weight:_____Sex:_____
Home Phone:_____Cell Phone:_____Work Phone:_____
Mailing Address:_____
Email Address:_____Occupation:_____
Significant Other Name:_____Occupation:_____
Significant Other Phone:_____
Emergency Contact Name:_____Emergency Number:_____
How Did You Hear About Dr. Harley?_____
What area(s) are you mostly interested in improving?_____

Previous Health Problems, Illnesses, and Diagnoses:

Prior Surgeries, Including Facial and Neck:

Medications, Including Herbals and Vitamins:

Allergies To Medications or Complications from Anesthesia:

Do you smoke currently?_____How much per day?_____
Do you take aspirin, ibuprofen, or another blood thinner on a regular basis?_____
Is there any chance you could be pregnant or become pregnant in the future?_____

Please Sign: I hereby attest that the above information is true to the best of my knowledge. I also acknowledge that a copy of the privacy policy has been made available to me.

Patient Signature:_____Date:_____

Printed Name:_____