Body By Benjamin

MEDICAL HISTORY

NAME _____ DATE _____

DATE OF YOUR LAST PHYSICAL EXAMINATION _____ WEIGHT _____ HEIGHT _____

SURGERY (OPERATIONS AND COSMETIC SRUGERY)

	TYPE	DATE	COMPLICATIONS OR DIFFICULTIES
1.			
2.			
3.			
4.			
5.			
6.			

MEDICAL PROBLEMS OR CONDITIONA NOW UNDER TREATMENT BY A PHYSICIAN

EXPLAIN _____

ADMISSIONS TO HOSPITAL

	REASON	DATE	COMPLICATIONS OR DIFFICULTIES
1.			
2.			
3.			
4.			

MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS YOU TAKE NOW

	TYPE	DOSAGE/AMOUNT IF KNOWN	TAKE HOW OFTEN
1.			
2.			
3.			
4.			

CONSUMPTION OF THE FOLLOWING

ASPIRIN _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

ALCOHOL _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

TOBACCO _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

OTHERS _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

BLEEDING PROBLEMS

DO YOU BRUISE OR BLEED EASILY? YES ☐ NO ☐ (WITH CUTS / TOOTH EXTRACTIONS / PREGNANCY / SURGERY)

EXPLAIN _____

DO YOU HAVE A FAMILY HISTORY OF BLEEDING PROBLEMS? EXPLAIN _____

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA

EXPLAIN _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES ☐ NO ☐

ARE YOU PREGNANT? YES ☐ NO ☐

HAVE YOU EVER HAD, HAVE OR BEEN EXPOSED TO (PLEASE CIRCLE YES OR NO)

YES ☐ NO ☐ INTRAVENOUS DRUGS
YES ☐ NO ☐ INFECTIOUS DISEASES
YES ☐ NO ☐ TB
YES ☐ NO ☐ HEPATITIS
YES ☐ NO ☐ HIV /AIDS
YES ☐ NO ☐ LIVER TRANSPLANT

IF YES TO ANY EXPLAIN _____

HISTORY OF EPILEPSY OR MENTAL ILLNESS

EXPLAIN_____

_____

CHILDHOOD MEDICAL HISTORY (PLEASE CIRLE YES, NO OR UNCERTAIN)

HAD ALL KNOWN "BABY SHOTS"? YES NO UNCERTAIN

HAD POLIO IMMUNIZATION? YES NO UNCERTAIN

HAD RHEUMATIC FEVER? YES NO UNCERTAIN

FAMILY HISTORY

ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?

MOTHER_____ SISTER_____

_____ _____

FATHER_____ BROTHER_____

_____ _____

OTHER RELATIVE:_____

REVIEW OF SYSTEMS

ANY MEDICAL PROBLEMS WITH ANY OF THE FOLLOWING:

NO_____ HEAD, IF YES EXPLAIN_____

NO_____ EYES, IF YES EXPLAIN_____

NO_____ EARS, IF YES EXPLAIN_____

NO_____ THYROID, IF YES EXPLAIN_____

NO_____ LUNGS, IF YES EXPLAIN_____

NO_____ HEART, IF YES EXPLAIN_____

NO_____ BLOOD PRESSURE OR VESSELS, IF YES EXPLAIN_____

NO_____ DIGESTIVE SYSTEMS, IF YES EXPLAIN_____

NO_____ LIVER, IF YES EXPLAIN_____

NO_____ MUSCLES-BONES, IF YES EXPLAIN_____

NO_____ REPRODUCTIVE ORGANS, IF YES EXPLAIN_____

NO_____ KIDNEY'S-BLADDER, IF YES EXPLAIN_____

NO_____ UNSIGHTLY SCARS, IF YES EXPLAIN_____

NO_____ OTHER, IF YES EXPLAIN_____

NO_____ DISEASE AFFECTING IMMUNE SYSTEM, IF YES EXPLAIN_____

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATION(S)? PLEASE LIST

_____

_____

_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PRACTICE NAME:_____

PHYSICIAN:_____

ADDRESS:_____

BY REPRESENTATION OF SIGNATURE BELOW, I HEREBY AUTHORIZE THE ABOVE STATED OFFICE TO FORWARD MY MEDICAL RECORDS TO:

Body By Benjamin - Dr. James R. Benjamin

7507 Old Chapel Dr Bowie, MD 20715

PHONE: 301-262-1118* FAX : 301-805-9417

_____ _____

PATIENT SIGNATURE DATE