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:________________________________