

Our Secret Medical Spa & Treatment Center

Michele M Zormeier MD, Cosmetic Surgeon

Please fill out the information below as concisely as possible:

Name: _____ Sex: Male / Female

Age: ____ Birth date: ____ / ____ / ____ Occupation: _____

Family Doctor: _____ Phone Number: (____) _____

Have you ever had problems, diseases, or injuries in the areas listed below:

	Yes	No	Explanation
Head / Eyes / Ears / Throat			
Nose			
Diabetes			
Stroke			
High Blood Pressure			
Shortness of Breath			
Lungs / Asthma			
Chronic Cough			
Heart Problems / Murmur			
Stomach Problems			
Headache History			
Bowel Problems			
Depression Problems			
Kidneys			
Psychiatric / Nervous			
Bladder			
Excessive Scarring			
Jaundice / Liver Problems			
Thyroid Problems			
Extremities			
Arthritis			
Circulation Problems			
Poor Healing in the Past			
Herpes / Cold Sores / Fever Blisters			
Epilepsy / Seizers			

Do you have a family history of medical problems? _____

Surgeries or hospitalization (include yr) _____

Allergies (to medication, Hay Fever, etc.) _____

Current medications (strength & dose, aspirin & NSAIDs included) _____

Current vitamins (type, strength, dose) _____

Habits (tobacco, alcohol, etc.) _____

Patient Signature: _____ Date: _____

Patient Signature: _____ Updated On: _____