306 South Greeno Road - Suite A
Fairhope, AL 36532
www.SelfCenter.com

SELF CENTER, P.C.

MEDICAL HISTORY

Phone (251) 928-8760
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All information is treated as confidential. **Please print or type and complete all information.**

Today's Date	Birthdate	Male ☐ Female ☐	Social Security #	Drivers License #

Last Name First Middle	Daytime Phone ( )	Home Phone ( )	Cell Phone ( )

Address City State Zip	Occupation	E-mail	Marital Status M S W D

Spouse Name	Birthdate	Social Security #	Spouse Occupation

Last Physical Exam Date	By What Physician	Phone # ( )	Family Physician	Phone # ( )

Family History	If Living Health Age	Good	Fair	Poor	If Deceased Death Age	Death Cause
Father						
Mother						
Brothers Sisters (Circle Sex) 1. M F						
2. M F						
3. M F						
4. M F						
5. M F						
Husband ☐ Wife ☐						
Sons Daughters (Circle Sex) 1. M F						
2. M F						
3. M F						
4. M F						
5. M F						

COSMETIC TREATMENTS

Botox®

Previous Botox Treatment Yes No
Date of last Treatment _____ Area _____

Line Fillers

Previous Filler Treatment Yes No
Juvederm® Perlane® Restylane®
Collagen® Radiance® Other _____
Date of last Treatment _____ Area _____

Have you ever had "fever blisters" (herpes simplex) Yes No

Do you now smoke? _____ **How many per day?** _____

How long ago did you stop smoking? _____

Habits

Do you	Circle		Daily Consumption
Smoke	Yes	No	_____ Pkgs.
Drink Coffee	Yes	No	_____ Cups
Drink Alcohol	Yes	No	_____ oz.
Drink Beer	Yes	No	_____ oz.
Fall Asleep Easily	Yes	No	
Awaken Early	Yes	No	

Diseases you have had requiring hospitalization	Year

Serious illness not requiring hospitalization	Year

What Medicines are you allergic to:

	Circle		Operations you have had (other than cosmetic):
Gallbladder Surgery	Yes	No	Others (list)
Hysterectomy . .	Yes	No	_____
Oophorectomy . .	Yes	No	_____
Tubal Ligation . .	Yes	No	_____

List all Prescribed Medication or over the counter drugs that you are taking:

Name of Medication:	Amount:	Frequency:

Have you ever had shortness of breath?	Circle	
Doing your usual work?	Yes	No
Climbing a flight of stairs? . . .	Yes	No
Which awakens you at night? . .	Yes	No
Do you have a chronic cough? . .	Yes	No
Accompanied by wheezing? . .	Yes	No
Have you ever coughed blood? .	Yes	No
Do you cough up much sputum? .	Yes	No

Have you had pain or tightness in the chest which begins:	Circle			Circle	
When exerting yourself? . . .	Yes	No	Radiates down the arm?	Yes	No
When walking up a hill? . . .	Yes	No	Disappears if you rest?	Yes	No
After a heavy meal?	Yes	No	Occurs only at rest?	Yes	No
When upset or excited? . . .	Yes	No	When walking fast?	Yes	No
Palpitations?	Yes	No	When walking in cold weather? . .	Yes	No
Heart rhythm problems? . . .	Yes	No	If you have chest pain or tightness please explain		

Please complete front and back of this form

Women only:	**Circle**	
Are you pregnant?	Yes	No
Are you nursing an infant?	Yes	No
Are you post menopausal?	Yes	No
Are you still having regular monthly menstrual periods?	Yes	No
Do you feel bloated and irritable before your period?	Yes	No
Are you now on or have you ever taken the birth control pills?	Yes	No
Date of last menstrual period _____		
How many cesarean operations?	Yes	No

Men only:	**Circle**	
Have you ever had:		
Loss of sexual activity? For how long?_____	Yes	No
Impotence?	Yes	No
Sexual Problems, other?	Yes	No
Prostate trouble?	Yes	No

Have you had or do you have:	**Circle**	
Glaucoma (narrow-angle)?	Yes	No
Glaucoma(open-angle)?	Yes	No
Medicine or treatment for above glaucoma?	Yes	No
Kidney/Renal dysfunction?	Yes	No
Emphysema?	Yes	No

Have you had or do you have:	**Circle**		**When or since when?**
A nervous problem?	Yes	No	
Alcohol problem?	Yes	No	
Drug problem?	Yes	No	
Treatment in an alcohol or drug abuse program?	Yes	No	
A depression episode?	Yes	No	
Any treatment for depression including medicines, counseling, in or out patient treatment?	Yes	No	
Any manic episodes?	Yes	No	
Any psychiactric diagnosis or psychological diagnosis?	Yes	No	
Suicidal thoughts or attemps?	Yes	No	
A convulsion/seizure?	Yes	No	
An abnormal electrocardiogram?	Yes	No	
Mitral Valve Prolapse?	Yes	No	

Current History

	Check if positive		Check if positive
Frequent headaches		Frequent diarrhea	
Dizziness		Irregular periods	
Fainting spells		No periods	
Convulsions		Painful periods	
Hard of hearing		Vaginal discharge	
Change in vision		Pregnancies (how many)	
Dental problems		Dry skin	
Difficulty swallowing		Feel cold alot	
Shortness of breath		Tiredness	
Wheezing		Blood in urine	
Skipping irregular heart		Painful urination	
Chest pains		Kidney Stones	
Indigestion		Joint pains	
Heartburn		Back trouble	
Chronic stomach pains		Hairloss	
Constipation		Other	

Past History

	Check if positive	
Pneumonia		
Tuberculosis		
Heart Attack		
Heart Failure		
Angina		
Rheumatic Fever		
Veneral Disease		
Kidney Trouble		
Diabetes age of onset		
Gout		
Stomach or duodenal ulcer		
Bowel Disease		
Psychiatric illness		
Drinking Problem		
Other		

May we contact you about appointments, new procedures or new information at the Self Center?
Via e-mail? Yes No
Via text message? Yes No

Your Age _____years
Height _____ ft. _____in. or _____cm.
Weight _____ lbs.or _____kg.

	Circle	
Have you ever had a blood clot?	Yes	No
In your legs or any part of your body?_____		
Have you ever had deep vein thrombophebitis or (infection in your legs)?	Yes	No
Have you ever had a bleeding problem(uncontrolled bleeding)?	Yes	No
Have you ever had a blood clot to your lungs (pulmonary emboli, (PE)?	Yes	No
Have you ever had a stroke?	Yes	No
If yes, bleeding or blood clot?_____		
Has your mother, father, or sibling had problems such as blood clots or bleeding?	Yes	No
Have you ever had a bad scar after any surgery?	Yes	No
Have you ever had a keloid?	Yes	No
Have you ever had liposuction?	Yes	No
What part of your body? _____		
When? _____		
Have you ever had any plastic surgery?	Yes	No
What part of your body? _____		
When _____		

I certify that the information above is truthful and accurate to the best of my knowledge.

_____ Signature

_____ Date

How did you hear about our Center? _____

Who referred you? _____

Address: _____