KALOS

MEDICAL HISTORY

GENERAL

_____ _____

Name *Date of Birth*

MEDICAL

Do you or have you had:

	No	Yes		No	Yes		No	Yes
Anemia	☐	☐	Dry Eyes	☐	☐	Kidney Disease	☐	☐
Anesthesia reaction	☐	☐	Epilepsy	☐	☐	Liver Disease	☐	☐
Arthritis	☐	☐	Fainting spells	☐	☐	Lung Disease	☐	☐
Asthma	☐	☐	Fibromyalgia	☐	☐	Migraine Headache	☐	☐
Back Pain	☐	☐	Glaucoma	☐	☐	Peptic Ulcer	☐	☐
Bleeding Tendency	☐	☐	Heart Disease	☐	☐	Pneumonia	☐	☐
Blood clots/DVT	☐	☐	Heart Murmur	☐	☐	Shortness of breath	☐	☐
Breast Cancer	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Herpes simplex/fever blisters	☐	☐	Thyroid Disease	☐	☐
Chest Pain	☐	☐	High Blood Pressure	☐	☐	Vision Deficits	☐	☐
Diabetes	☐	☐	HIV/Aids	☐	☐	Wheezing	☐	☐

If yes or other, please describe:

SURGICAL

Previous Operations:

_____ _____ _____ _____

Surgery *Date* *Surgery* *Date*

_____ _____ _____ _____

Surgery *Date* *Surgery* *Date*

_____ _____ _____ _____

Surgery *Date* *Surgery* *Date*

CURRENT MEDICATIONS

Do you take:

	No	Yes		No	Yes
Aspirin or Ibuprofen	☐	☐	Vitamins & Herbal Supplements	☐	☐
Coumadin (Warfarin)	☐	☐	Steroids in the past year	☐	☐
Arthritis Medicine	☐	☐	Retin A	☐	☐
Birth Control Pills	☐	☐	Accutane	☐	☐

List other medication you are currently taking:

Are you allergic to any medications? No ☐ Yes ☐ *If yes, please list:*

SCARRING

Have you formed excessive or unsatisfactory scars/keloids/hypertrophy in the past? No ☐ Yes ☐

PERSONAL HISTORY

Do you smoke? No ☐ Yes ☐ _____ *packs per day*

Do you drink alcohol? No ☐ Yes ☐ _____ *per week*

WOMEN ONLY:

Have you ever been pregnant? No ☐ Yes ☐

Are you breast feeding? No ☐ Yes ☐

Are you pregnant now? No ☐ Yes ☐