Cosmedical Esthetics at
The ENT Center of New Braunfels
948 Gruene Rd., Ste. 120
New Braunfels, TX 78130

Past Medical History Information

Patient's Name: ____ Today's Date: _________________________________
Address: ____
Phone Number: _____________________ Email Address: ____
Referred From: ____ Date of Birth: _________________________________

Have you ever been hospitalized? **Yes** **No** If yes, what for? ____
____

Please circle **Yes** if you have or **No** if you do not have each of the medical conditions listed.

Angina (heart pain)	**Yes**	**No**
Hypertension (high blood pressure)	**Yes**	**No**
Diabetes (high blood sugar)	**Yes**	**No**
Renal Disease (kidney disease)	**Yes**	**No**
Respiratory Illness (lung problems)	**Yes**	**No**
Bleeding Disorder	**Yes**	**No**
Seasonal Allergies	**Yes**	**No**
HIV/AIDS	**Yes**	**No**
Cancer	**Yes**	**No**
Sinus Problems	**Yes**	**No**
Recent Viral Illness (flu-like illness)	**Yes**	**No**
Currently Pregnant	**Yes**	**No**
Currently Breast-feeding	**Yes**	**No**
Tendency to getting cold sores	**Yes**	**No**

Please describe any current or past medical condition or treatment not listed above: ____
____
____

Please list your past surgeries: ____
Do you currently smoke or chew tobacco? **Yes** **No** If no, have you in the past? **Yes** **No** How many packs per day? _____
Do you drink alcohol, beer, or wine? **Yes** **No** If no, have you in the past? **Yes** **No** How often? _________________

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient Signature ____ **Date** _________________________