CAPSTONE
MEDICAL ASSOCIATES

PAST & PRESENT HEALTH HISTORY

Name (Last, First, MI): _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

E-Mail: _____

Social Security Number: _____ Height: _____ Weight: _____

Emergency Contact: _____ Phone: _____

Preferred Method of Contact (Check All that Apply): Home _____ Work _____ Cell _____ Email _____

Do we have permission to leave a message at your preferred contact? Yes _____ No _____

Whom may we thank for the referral? _____

Are you currently under the care of a physician? Yes ____ No ____ Name of Physician: _____

Do You Now, or Have You Had in the Past (Check Yes or No)

Yes	No		Yes	No	
____	____	History of Heart Problems, Chest Pain or Stroke	____	____	Fatigue
____	____	Any Chronic Illness or Condition	____	____	Anxiety
____	____	Recent Surgery (last 12 months)	____	____	Depression
____	____	High Blood Pressure	____	____	Tanning within Last 30 Days
____	____	Pregnancy (now or within last 3 months)	____	____	Epilepsy
____	____	History of Breathing/Lung Problems	____	____	Keloid Formations
____	____	Muscle, Joint, or Back Disorder, or Any Previous Injury still Affecting You	____	____	Open Sores
____	____	Diabetes	____	____	Cold Sores
____	____	Thyroid Condition	____	____	Herpes
____	____	Obesity (more than 20% over ideal body weight)	____	____	Fever Blisters
____	____	Increased Cholesterol	____	____	Skin Cancer
____	____	History of Heart Problems in Immediate Family	____	____	Sensitive Skin
____	____	Arthritis	____	____	Radiotherapy or Chemotherapy in Past 3 Months
____	____	Bursitis	____	____	Do You Smoke? If so, How Many a Day _____
____	____	Muscle Tension	____	____	Drink Alcohol? If so, How Often _____
			____	____	Hepatitis

Please Explain any YES Answers or Other Concerns:

_____

_____

_____

4807 Jonestown Road, Suite 141, Harrisburg, PA 17109 717-695-6177

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PAST & PRESENT HEALTH HISTORY, Cont.

Have you had any previous surgeries? If so, please list all surgeries and dates performed:

_____
_____
_____
_____

List all physicians you have seen in the last 6 months:

_____
_____

List medications you are currently taking or have taken in the past 6 months:

_____
_____
_____

List any drug allergies:

_____

List any other known allergies (Example: LATEX):

_____

List any procedures you have had at a Spa or Medical Spa and negative results, if any:

_____
_____

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I understand that the staff employed at the facility is not qualified to make medical assessments of my health and it is my responsibility to check with my physician before starting any treatment program.

Patient Signature: _____ Date: _____

Physician Signature: _____
Jeffrey J. Backenstoes, DO, ABAARM, FAARFM

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