Cosmetic Surgery
CENTER

Health History Questionnaire

DATE: ______________________ PATIENT NAME: ____

E-MAIL: ____ DATE OF BIRTH: ________________________

AGE: __________ HEIGHT: ______________ WEIGHT: ______________

MARITAL STATUS (circle one): Single | Married | Separated | Divorced | Widow

EMERGENCY CONTACT: ______________________________ PHONE:________________________________

RELATIONSHIP: ____

FAMILY PHYSICIAN:__________________________PHONE:________CITY/STATE:______________________

Do we have permission to obtain additional health information from your family physician? ☐ Yes ☐ No

When was your last physical examination? ____

Do you have an ADVANCED DIRECTIVE? ☐ Yes ☐ No

If No, Would you like information on an Advanced Directive? ☐ Yes ☐ No

Do you have any allergies to medications or LATEX, iodine or tape? ☐ Yes ☐ No

If yes, please list: ____

Are you currently taking ANY medications? ☐ Yes ☐ No

If yes, please list: ____

Do you take any Herbal or nutritional supplements? ☐ Yes ☐ No

If yes, please list: ____

Are you currently taking aspirin, ibuprofen, birth control pills or weight loss medication? ☐ Yes ☐ No

If yes, please list. ____

Have you had previous cosmetic, plastic or reconstructive surgery? ☐ Yes ☐ No

If yes, please list what type of surgery? ______________________________Date ______________________

By whom? ____

Are you interested in improving the quality of your skin? ☐ Yes ☐ No

Have you ever had any other type of surgery? ☐ Yes ☐ No

Type of surgery ______________________ Date ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Did you experience any complications? ☐ Yes ☐ No

If yes, please specify: ______________________

Have you or any of your family members had a high fever with anesthesia? ☐ Yes ☐ No

If yes, please explain: ______________________

Do you now smoke cigarettes, use tobacco products or have you ever used them? ☐ Yes ☐ No

If yes, how many per day?______________________ For how long? ______________________

If you quit smoking, when did you quit? ______________________

Have you ever experienced an adverse reaction to general anesthesia or IV Sedation? ☐ Yes ☐ No

If yes, please describe the type of reaction: ______________________

Have you ever had problems with local anesthesia (Novocain, Xylocaine, etc)? ☐ Yes ☐ No

Do you have a history of excessive or spontaneous bleeding? ☐ Yes ☐ No

If yes, please specify: ______________________

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, when? ______________________

Do you drink more than 6 cups of coffee per day? ☐ Yes ☐ No

Do you normally have more than 2 drinks of alcohol per day? ☐ Yes ☐ No

Have you ever been under the care of a psychologist or psychiatrist? ☐ Yes ☐ No

If yes, please explain: ______________________

PLEASE CHECK ALL THAT APPLY TO YOU CURRENTLY OR IN THE PAST

Condition	Yes	No	Condition	Yes	No
Allergies	☐ Yes	☐ No	High / Low Blood Pressure	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Nasal Allergies	☐ Yes	☐ No	Bladder Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Vision / Eyes	☐ Yes	☐ No	Decreased circulation (fingers/toes)	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Skin Infections	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No	Skin Irritations	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Herpes or fever blisters	☐ Yes	☐ No
Gall Bladder Disease	☐ Yes	☐ No	AIDS or positive HIV test	☐ Yes	☐ No
Hepatitis / Jaundice	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Severe Headaches	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Paralysis/Numbness	☐ Yes	☐ No	Heart Murmur / Mitral Valve Prolapse	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Autoimmune Disease (Lupus, MS)	☐ Yes	☐ No
Heart Attack/Arrhythmia	☐ Yes	☐ No	Drug abuse	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Blood Clot / Pulmonary Embolism	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Other	☐ Yes	☐ No

If you answered yes to any of the above, please explain and list medications that are being used to treat the condition:

____

____

WOMEN

Is there a history of breast cancer in your family? ☐ Yes ☐ No

If yes, please specify (check all that apply):

MOTHER'S SIDE		**FATHER'S SIDE**	
___ YES	___ NO	___ YES	___ NO
___ MOTHER	___ SISTER	___ MOTHER	___ SISTER
___ GRANDMOTHER	___ AUNT	___ GRANDMOTHER	___ AUNT

Have you ever had a mammogram? ☐ Yes ☐ No

If yes, date of last mammogram______________________________

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Do you have heavy menstrual periods? ☐ Yes ☐ No

When was the first day of your last period? ______________________________

Number of children: ______ Number of pregnancies: _______ Number of children breastfed: _________

Date of last breast feeding: ________________________

MEN

Have you ever had prostate problems? ☐ Yes ☐ No

Do you use sexual performance drugs such as Viagra, Levitra, Cialis, etc.? ☐ Yes ☐ No

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Patient's signature ______________________________ Date ____________________

Physician's signature ______________________________ Date ____________________