Cosmetic Surgery CENTER

Health History Questionnaire

Date _____

Patient Name _____ DOB_____

Height _____ Weight _____ Is your Weight Stable? Yes No

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?

_____

Pharmacy Name, Location & Phone Number: _____

Do you have an ADVANCED DIRECTIVE (Living Will)? Yes No

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

Do you have any allergies to medications, iodine or tape? Yes No If yes, please list:

_____

_____

Are you allergic to Latex? Yes No

Are you currently taking any medications?

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

Surgeon Name & Practice _____

So you have a history of developing fever blisters? Yes No (even 1 occurrence)

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

Type of surgery Date

_____ _____

_____ _____

_____ _____

_____ _____

Did you experience any complications with any of your surgeries? If yes, please specify:

_____

_____

_____

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 so when? _____

Social History

Do you now smoke cigarettes, cigars, or pipes? Yes No

If yes, Packs/day per day? _____ For how many years?

_____

Have you quit smoking? Yes No When did you quit? _____

Do you use a nicotine patch or gum?	Yes	No	
Do you use smokeless tobacco?	Yes	No	
Do you drink alcohol, wine or beer?	Yes	No	How much per week? _____
Have you ever injected recreational drugs?	Yes	No	What? _____
Do you drink coffee?	Yes	No	Cups per day? _____

It is extremely important that you let us know if you are smoking. Severe surgical complications due to smoking can arise IF we are not prepared for them. Smoking can have a detrimental effect on wound healing.

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

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: _____

Have you had a history of any psychiatric illness or condition? Yes No
If yes, please explain:

_____

Is there a history of breast cancer in your family? Yes No
If yes, please specify:. **MOTHER'S SIDE**:__yes __no **FATHER'S SIDE**: __yes __no
___mother ___ sister ___mother ___ sister
___grandmother ___aunt ___grandmother ___aunt

Women Only:

Is there a chance you may be pregnant?	Yes	No
Are you trying to get pregnant?	Yes	No
Have you had a recent bladder infection?	Yes	No
Do you still have regular menstrual periods?	Yes	No
Do you have menstrual problems?	Yes	No
Explain:_____		
Have you ever taken birth control pills?	Yes	No
Have you ever used hormones?	Yes	No
When?_____		

Have you had a mammogram? Yes No Date:_____ Results:_____
Did you breast feed your children? Yes No Date stopped:_____

Number of pregnancies:_____Live births:_____ Miscarriages/terminations:_____

Men Only:

Have you ever had prostate problems?	Yes	No
Do you use sexual performance drugs? (Viagra, Levitra, Cialis, etc?)	Yes	No

Patient Signature: _____ **Date:**_____

Patient Signature Updated: _____ **Date:**_____

Physician Signature: _____ **Date:**_____