

SURGERY/COSMETIC PATIENT HEALTH HISTORY

Complete the information on this form and bring a printed copy to your appointment.

Date _____ Referred By _____

Patient Name _____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ Phone (cell) _____ E-mail _____

Date of Birth _____ Age _____ Marital Status _____

Employer, Name and Phone _____

Emergency Contact _____ Phone _____ Relationship _____

Family Physician _____ Phone _____ City / State _____

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

Do you have any allergies or sensitivities? Yes No If yes, please list _____

Are you currently taking any medications? Yes No If yes, please list _____

Are you currently taking aspirin, ibuprofen, minerals, herbs, nutritional supplements, birth control pills or sexual performance drugs? Yes No

If yes, please list. _____

Please check the procedure(s) in which you are interested.

- | | | |
|------------------|--------------------|---------------|
| Eyelid Surgery | QuickLift™ | Chemical Peel |
| Neck Liposuction | Silikon Injections | Brow Lift |
| Botox Injection | Fat Transfer | |
| Other | | |

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

What type of surgery? _____

By whom? _____

Where there aspects of your surgery that did not meet your expectations? Yes No

If yes, please specify _____

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

Type of surgery _____ Date _____

Type of surgery _____ Date _____

Did you experience any complications? Yes No

If yes, please specify _____

Have you ever had local anesthesia (Novocain, Xylocaine, etc) by a dentist or doctor? Yes No

Have you ever experienced an adverse reaction to anesthesia? Yes No

If yes, please describe the type of reaction _____

When was your last physical examination? _____

Do you have a history of bleeding? Yes No

If yes, please specify _____

Please explain and list any other bleeding problems. _____

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	Skin Rashes	Yes	No
Liver Disease	Yes	No	Herpes	Yes	No
Gall Bladder Disease	Yes	No	HIV/Aids	Yes	No
Yellow 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	Mitral Valve Prolapse	Yes	No
Bruise Easily	Yes	No	Autoimmune Disease (Lupus, MS)	Yes	No

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

Are you frequently sick or ill? Yes No

Have you ever taken hormone or thyroid medications? Yes No

Do you smoke cigarettes? Yes No

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. _____

Do you or any family members have the following (please indicate relationship)?

Heart trouble	Yes	No	Relationship _____
Excessive bleeding	Yes	No	Relationship _____
Diabetes	Yes	No	Relationship _____
Thyroid problems	Yes	No	Relationship _____
Excessive bruising	Yes	No	Relationship _____
Unfavorable/wide scarring	Yes	No	Relationship _____
Delayed or poor healing	Yes	No	Relationship _____
Psychiatric or nerve problems	Yes	No	Relationship _____
Arthritis	Yes	No	Relationship _____
High blood pressure	Yes	No	Relationship _____
Low blood pressure	Yes	No	Relationship _____
Depression	Yes	No	Relationship _____
Other _____	Yes	No	Relationship _____

Do you understand that medical and surgical treatments cannot promise or guarantee a good outcome? Yes No

Do you understand that all risks and complications cannot be prevented when a surgical procedure is performed? Yes No

Thank you.

Patient's signature _____ Date _____

Physician's signature _____ Date _____

Reviewed by _____ Date _____