COSMETIC AND RECONSTRUCTIVE PLASTIC SURGERY CENTER

HEALTH HISTORY

NAME_____AGE_____SEX_____HGT._____WGT._____

PLEASE CIRCLE IF YOU HAVE A HISTORY OF:

GENERAL – WEIGHT LOSS, SEXUALLY/BLOOD TRANSMITTED DISEASE.

EYES – BLURRED VISION, DOUBLE VISION, GLAUCOMA.

ENT - PERSISTENT SORE THROAT, BLEEDING GUMS.

RESPIRATORY – PERSISTENT COUGH, ASTHMA, LUNG PROBLEMS.

CARDIOVASCULAR – CHEST PAIN, IRREGULAR HEART BEAT, HEART ATTACK, HEART PROBLEMS.

GASTROINTESTINAL – BLOOD IN STOOL, CHANGE IN BOWEL HABITS, LIVER DISEASE.

GENITOURINARY – BURNING ON URINATION, BLOOD IN THE URINE, KIDNEY OR BLADDER PROBLEMS.

MUSCULOSKELETAL – BACK PAIN, JOINT PAIN.

ENDOCRINE – DIABETES, THYROID DISEASE.

LYMPH/HEMO – PROLONGED BLEEDING, SWOLLEN “GLANDS”

NEUROLOGICAL – DIZZINESS, FAINTING EPISODES, SEIZURES.

PSYCHIATRIC – NERVOUS BREAKDOWN OR MENTAL ILLNESS.

DO YOU HAVE ANY DRUG ALLERGIES (IF YOU HAVE HAD ANY DRUG ALLERGIES, PLEASE LIST THE TYPE OF REACTION SUCH AS HIVES, RASH, SHORTNESS OF BREATH OR OTHER REACTIONS).

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MEDICATIONS (PLEASE INCLUDE DOSAGE AND FREQUENCY)

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PAST SURGERY:

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PAST OR PRESENT MEDICAL CONDITIONS OR ILLNESSES:

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ARE THERE ANY MEDICAL CONDITIONS WHICH SEEM TO RUN IN YOUR FAMILY? IF YES, PLEASE EXPLAIN.

_____

DO YOU SMOKE: YES_____ NO_____ HOW MUCH_____ HOW MANY YEARS_____

DO YOU DRINK ALCOHOL: YES____ NO_____ HOW MUCH_____ EVERYDAY_____

FOR WOMEN - LAST MENSTRUAL PERIOD_____

PATIENT SIGNATURE_____ DATE_____

PHYSICIAN SIGNATURE_____ DATE_____