DEVLIN
COSMETIC SURGERY

Health History Questionnaire

Date_____

Patient Name_____

E-mail_____

Date Of Birth_____Age_____Height_____Weight_____

Family Physician_____Phone_____City/State_____

When was your last physical examination?_____

Have you ever had a Chest X-ray? Yes No When?_____ EKG? Yes No When_____

What procedure are you interested in having?_____

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

If yes, please list_____

_____

Are you allergic to Latex? Yes No

Have you ever had an adverse reaction to any skin related procedures or cosmetics? Yes No

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 BEEN DIAGNOSED WITH OR CURRENTLY HAVING PROBLEMS WITH ANY OF THE FOLLOWING:

Allergies/Seasonal/Nasal	Yes	No	Stroke/TIA	Yes	No
Dry Eyes/Blurred Vision/Glaucoma	Yes	No	Severe Headaches	Yes	No
Coronary Artery disease	Yes	No	Dizzy/Fainting Spells	Yes	No
Heart Attack/Irregular heart beat	Yes	No	Seizures/Convulsions	Yes	No
Pacemaker	Yes	No	Paralysis/Numbness/Muscle weakness	Yes	No
Heart Murmur/Valve Problems	Yes	No	Abnormal Circulation	Yes	No
Mitral Valve Prolapse	Yes	No	Clotting Problems/ Bruising/Bleeding	Yes	No
Gall Bladder Disease	Yes	No	Anemia	Yes	No
Stomach Ulcers/Reflux	Yes	No	Thyroid Disease	Yes	No
Lung Disease/COPD/Emphysema	Yes	No	Arthritis/Fibromyalgia	Yes	No
Shortness Of Breath	Yes	No	Autoimmune Disease(Lupus, MS)	Yes	No
Asthma	Yes	No	AIDS or Positive HIV Test	Yes	No
Sleep Apnea	Yes	No	Cancer	Yes	No
Coughing/Spitting up Blood	Yes	No	Sexually Transmitted Disease	Yes	No
Tuberculosis	Yes	No	Cold Sores or Fever Blisters	Yes	No
Blood Clot in Lungs or Legs	Yes	No	Skin Irritations (Eczema, Psoriasis)	Yes	No
High/Low Blood Pressure	Yes	No	Abnormal Scarring	Yes	No
Diabetes	Yes	No	MRSA Infection/Staph Infection	Yes	No
Kidney/Bladder Disease	Yes	No	Drug Dependency/Alcohol Abuse	Yes	No
Cirrhosis	Yes	No	Depression/Anxiety/Bipolar Disorder	Yes	No
Liver Disease	Yes	No	Loose Teeth/Dentures	Yes	No
Hepatitis	Yes	No	Previous Blood Transfusion	Yes	No
Pancreatitis	Yes	No	Diseases or Problems not listed above	Yes	No

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

_____

_____

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

Type of Surgery_____ Date_____

_____ _____

_____ _____

_____ _____

_____ _____

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 ever experienced an adverse reaction to general anesthesia, local anesthesia (Novocain, Xylocaine) or to IV Sedation? Yes No

If yes, please describe the type of reaction_____

Do you now smoke cigarettes, use tobacco products or have you ever used them?

Yes No

If yes, how much per day?_____ For how long?_____

If you quit smoking, when did you quit?_____

*Any patient with a history of smoking will be given a urine test at the preoperative appointment AND the day of surgery to verify that they are nicotine free. **PATIENTS WHO FAIL THEIR NICOTINE TEST WILL HAVE THEIR PROCEDURE CANCELLED AND ARE SUBJECT TO CANCELLATION FEES.**

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

Do you normally have more than 2 alcoholic drinks per day? Yes No

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

If yes, please explain_____

_____

WOMEN 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

Have you ever had a mammogram? Yes No

If yes, date of last mammogram _____Location_____

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?_____

Have you ever had a Tubal Ligation or Hysterectomy? Yes No

Number of Children_____ Number of Pregnancies_____

Number of Children breastfed_____ Date of last breastfeeding_____

MEN Do you use sexual performance drugs such as Viagra, Levitra, Cialis? Yes No

Have you in the past or do you currently use steroids? Yes No

I consent to the taking of photographs of me or parts of my body by Dr. Michael A. Devlin or his designee, as part of my medical record. Preoperative and postoperative photographs of my person will be used for confidential clinical record purposes only, and shall remain the property of Dr. Michael A. Devlin, M.D. _____

Patient Initials

Do you understand that the goal of Cosmetic Surgery is an elective change in appearance, not "perfection", after a procedure it is possible for imperfections to persist and may not live up to unrealistic expectations. _____

Patient Initials

Patient's Signature_____Date_____

Physician's signature_____Date_____