



PATIENT HEALTH HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

What are you seeing the Doctor for today ? \_\_\_\_\_

Please list all medications you are currently taking, include the dosage and how often taken. Also Include over-the-counter medications, homeopathic/nutritional supplements or multi vitamins. Especially important are Vitamin E, Aspirin, Ibuprofen, Motrin, St. John's Wort or any DIET PILLS.

NO MEDICATIONS TAKEN

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Are you ALLERGIC or SENSITIVE to any medications, food or Latex/Rubber? YES NO

If yes, please list the medication and the reaction.

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

PLEASE LIST ALL PREVIOUS SURGERY (any cosmetic surgery also):

If more room is needed, please continue on backside of this paper

Table with columns: Operation, Year, Hospital

Do you smoke ? Yes No If yes, how much and how long \_\_\_\_\_

Do you drink Alcohol? Yes No If yes, how much/frequency \_\_\_\_\_

Do you use recreational drugs? Yes No If yes, describe \_\_\_\_\_

Have you or any relative ever had a bad or unusual reaction to any type of anesthesia? Yes No

Have you or anyone in your family been diagnosed with cancer? Type \_\_\_\_\_ Yes No

Are you are being seen as the result of an injury or accident? Date of accident \_\_\_\_\_ Yes No

Family history of significant medical issues? \_\_\_\_\_ Yes No

Have you seen another plastic surgeon for the SAME issue that brings you to this office? Yes No

Physician Notes:

**REVIEW OF SYSTEMS**

**Check Yes or No by the current ailment as it applies to YOU. If unsure, place a question mark (?)**

**General**

<b>Yes</b>	<b>No</b>	
___	___	Weight loss greater than 10 lbs in last year
___	___	Fever
___	___	Trouble sleeping
___	___	Poor Appetite
___	___	Prior Trauma

**Eyes**

___	___	Glasses/Contacts
___	___	Loss or Change of Vision
___	___	Glaucoma or Cataracts
___	___	Dry Eyes
___	___	Frequent use of Eyedrops

**Ear, Nose and Throat**

___	___	Trouble breathing out of your nose
___	___	Nose bleeds
___	___	Hearing Aids/Hearing loss
___	___	Recurrent Ear infections
___	___	Sore throat/Strep Throat

**Cardiovascular**

___	___	High Blood Pressure
___	___	Heart Murmur
___	___	Mitral Valve Prolapse
___	___	Irregular heartbeat
___	___	Previous Heart Attack
___	___	Chest Pain
___	___	Deep Vein Thrombosis (DVT)
___	___	History of blood clots/bleeding

**Respiratory**

___	___	Shortness of Breath
___	___	Asthma
___	___	History of Tuberculosis (TB)
___	___	Chronic Cough
___	___	Emphysema
___	___	COPD (chronic obstructive pulmonary disease)
___	___	History of Apnea/Use CPAP
___	___	Pulmonary Embolism (PE)

**Gastrointestinal**

___	___	Ulcers
___	___	History of Jaundice or Cirrhosis
___	___	Heart burn /reflux/GERD
___	___	Hernia

Patient's Signature \_\_\_\_\_

Physician's Signature \_\_\_\_\_

**Females ONLY**

<b>Yes</b>	<b>No</b>	
___	___	Prior Breast Biopsy
___	___	Breast Lumps
___	___	Bloody Nipple Discharge
___	___	Abnormal Mammogram
___	___	Date of last Mammogram _____
___	___	Birth Control?
___	___	Method _____
___	___	History of Breast Cancer-Self or Family
___	___	_____
___	___	Are you pregnant?
___	___	Will you have any more children?

**Genitorurinary**

___	___	Problems Urinating-Incontinence/Burning/Frequency
___	___	Bladder Infections

**Skin**

___	___	Skin Cancer
___	___	Where/Type _____
___	___	Problems with Scarring
___	___	Describe _____
___	___	Ever use Accutane? When? _____
___	___	Bruise Easily

**Neuro**

___	___	Blackouts/Fainting/Confusion
___	___	Seizures/Stroke

**Pshychiatric**

___	___	Severe Depression History
___	___	Prior Counseling/Inpatient Treatment
___	___	Other _____

**Endocrine**

___	___	Diabetes
___	___	Thyroid Problems

**Allergy/Immunologic**

___	___	Latex Allergy
___	___	HIV/AIDS
___	___	MRSA

**Hematologic/Lymphatic**

___	___	Bleeding Disorders
___	___	Enlarged Lymph Nodes

Date \_\_\_\_\_

Date \_\_\_\_\_