PLASTIC SURGERY AESTHETICS, P.C. **PATIENT HISTORY**

NAME: ______________________________ Date: ______________
DOB: ______________ Age: ________ Sex: M ____ F ____ Height: __________ Weight: __________
Primary Care Physician: ______________________________ Date Last Seen: ______________
Married: Yes _____ N _____ Occupation: ______________________________
Responsible Adult Available to Assist During Recovery Period: Y _____ N _____ Relationship: ______________

HEALTH HABITS:

Smoke: Y ____ N ____ Amount: __________ Caffeine: Coffee/Tea/Cola Y ____ N ____ Amount: __________
Alcohol: Y ____ N ____ Amount: __________ Daily Exercise: Y ____ N ____ Amount: __________

MEDICATIONS: (Prescription & Nonprescription including Vitamins/Herbs)

Drug Name / Strength / Frequency

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Regular Aspirin Use: Y ____ N ____ Dosage & frequency: ______________________________
Advil, Motrin, Ibuprofen: Y ____ N ____ Dosage & frequency: ______________________________
Cortisone /Steroid Use Past Year: Y ____ N ____ Date(s) and inmjection location: ______________________________
"Street" or Recreational Drug Use: Y ____ N ____ ______________________________

ALLERGIES:

Known Drug/Medication Allergies: Y ____ N ____ Food Allergy/Hay Fever/Other Allergies: Y ____ N ____
List Drug(s) and Type of Recreation: ______________________________
.______________________________
Latex Allergy / Sensitivity: Y ____ N ____ Tape Allergy / Sensitivity: Y _____ N _____

FAMILY MEDICAL HISTORY: Have any blood relatives ever had the following problems:

Abnormal Bleeding: Y ____ N ____ Heart Disease: Y ____ N ____
Abnormal Clotting: Y ____ N ____ High Blood Pressure: Y ____ N ____
Cancer: Y ____ N ____ Kidney Disease: Y ____ N ____
Diabetes: Y ____ N ____ Lung Disease: Y ____ N ____
Other Serious Illness: Y ____ N ____
Please describe "Yes" answers: ______________________________
.______________________________

PERSONAL MEDICAL HISTORY: Have you ever had:

Abnormal Bleeding: Y ____ N ____ Diabetes: Y ____ N ____ Lung Disease: Y ____ N ____
Abnormal Clotting: Y ____ N ____ Fainting Spell: Y ____ N ____ Radiation Treatments: Y ____ N ____
Acid Reflux: Y ____ N ____ Heart Problems: Y ____ N ____ Seizures: Y ____ N ____
Anemia: Y ____ N ____ Hepatitis: Y ____ N ____ Sleep Apnea/Snoring: Y ____ N ____
Anxiety/Depression: Y ____ N ____ High Blood Pressure: Y ____ N ____ Stroke: Y ____ N ____
Cancer: Y ____ N ____ Kidney Disease: Y ____ N ____ Weight Change In 12 Mo: Y ____ N ____
Other Serious Illness: Y ____ N ____
Please describe "Yes" answers: ______________________________
.______________________________

Personal Medical History (Continued)

Have you ever received a transfusion? Y ____ N ____ If yes, what year? ________________________________
Have you been tested for HIV? Y ____ N ____ If yes, what year? ________________________________
Do you wear: Contact Lenses: Y ____ N ____ Eye Glasses: Y ____ N ____ Hearing Aid: Y ____ N ____ Dentures: Y ____ N ____

(WOMEN PATIENTS ONLY)
Number of Pregnancies ________ Number of Children ________ Did you breast feed? Y ____ N ____
Any Chance of Pregnancy: Y ____ N ____ Birth Control Method: ______________ Last Menstrual Period ____________
Date of Last Mammogram: ____________ Where: Med Assoc ____ MMC ____ Finley ____ DIM ____ Other ____________
Any history of breast problems/biopsy: ____
Family history of breast problems: ____

PREVIOUS SURGERIES: List date and type of procedure(s):

.____
.____
.____
.____
.____

ANESTHESIA HISTORY:

Have either you or your blood relatives ever have any problems with anesthesia? Y ____ N ____
Indicate the type(s) of anesthesia received in the past and list any complications/reactions you experienced:

____ Local anesthesia (complications/reactions): ____
____ General anesthesia (complications/reactions): ____
____ Spinal/Epidural (complications/reactions): ____

If family member; what was their reaction or complication? ________________________________

Patient Signature: ________________________________ Date:: ____________________

Reviewed with patient by: ________________________________ Date: ____________________

Health History Updated:
By: ________________________________ Date: ____________________
By: ________________________________ Date: ____________________
By: ________________________________ Date: ____________________

*Medical records are intermittently reviewed to ensure appropriate and quality medical care is provided to all our patients. Records are randomly selected and reviewed in a confidential manner by another physician. All information is kept strictly confidential. Your signature below indicates that you are aware of our Peer Review Policy and allow release of your non-identifiable health information for review by another physician.

Patient Signature: ________________________________ Date:: ____________________