Health Information as of date:_____

(Please Print Legibly & Fill In or Correct All Fields)

Patient: **Email address:**		
Address: Apt. # City State Zip Code		
Phone: Cell:	**SSN:**	**DOB:**
What surgery are you considering? Breast Body Face Eyes Botox Laser Other: Referred by:		Height: Weight:
Have you ever been involved in any medical litigation? Emergency Contact: Phone: Relationship:		Occupation:

DO YOU NOW OR HAVE YOU EVER HAD........... (You must circle an answer for each individual item)

Abdominal Bleeding YES NO
Abnormal Bleeding after Tooth Extraction YES NO
Abnormal EKG YES NO
Airway Obstruction (Nasal) YES NO
Alcoholism or Drug Dependency YES NO
Arthritis YES NO
Asthma YES NO
Black Outs YES NO
Bleeding Tendency or Disorder YES NO
Blood Pressure Abnormalities YES NO

Blood Transfusion YES NO
Breast Cancer YES NO
Bronchitis YES NO
Cancer YES NO
Chest Pain YES NO
Chest Pain / Tightness YES NO
Cirrhosis of the Liver YES NO
Colitis YES NO
Cosmetic bonding to teeth YES NO
Coughing or Spitting of Blood YES NO
Dentures, Bridges, Capped Teeth or Crowns YES NO
Diabetes YES NO
Digitalis Treatment YES NO
Drug Habit YES NO
Eczema YES NO
Emphysema YES NO

Glaucoma or Eye Problems YES NO
Goiter or Thyroid Disorders YES NO
Glaucoma or Eye Problems YES NO
Goiter or Thyroid Disorders YES NO
Hay Fever YES NO
Heart Disease YES NO
Heart Failure YES NO
Heart Murmur YES NO
Hemorrhoids YES NO
Hepatitis YES NO
High Blood Pressure / Hypertension YES NO
Hives YES NO
Insomnia YES NO
Kidney Disorder YES NO
Kidney or Renal Disease YES NO

Kidney Stones YES NO
Loose teeth YES NO
Missed or irregular last menstrual period YES NO
Nervous Breakdown YES NO
Nervous Disorder YES NO
Nipple Discharge (Apart from Normal Lactation) YES NO
Palsy or Paralysis YES NO
Piercing other than the Ears YES NO
Pneumonia YES NO
Positive Blood test for: HIV, AIDS, Hepatitis YES NO
Problem Constipation YES NO

Esophageal Varices YES NO Psychiatric Hospitalizations or Care YES NO

Fracture of Neck or Spine YES NO
Frequent Indigestion YES NO
Gallstones or Gallbladder Trouble YES NO
Gastritis YES NO
Skin Cancer YES NO
Skin Disease YES NO
Skin Disorders YES NO
Smokers Cough YES NO
Stroke YES NO
Tarry or Bloody Bowel Movements YES NO
Thyroid Disorder YES NO

Rheumatic Fever YES NO
Seizures or Convulsions or Fainting Spells YES NO
Self-Destructive Tendencies YES NO
Shortness of Breath YES NO
Thyroid Problems YES NO

Tuberculosis YES NO
Ulcers YES NO
Visual Disturbances YES NO
Vomiting Blood YES NO
Xray Therapy YES NO
Yellow Jaundice YES NO

HAS ANYONE IN YOUR FAMILY EVER HAD....

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, and weight loss drugs. **Include over-the-counter medications.**

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2.Do you have an allergic reaction to any medication? ❒Yes ❒No Which? ___________________________ 3.Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used

for anesthesia?

❒Yes ❒No If yes, when and where? ____ 4.Have you ever been on cortisone or steroid treatment? ❒Yes ❒No When? __________________________ 5.Do you smoke? ❒Yes ❒No If so, how much? _________________ For how long? ___________________

6.Are you pregnant? ❒Yes ❒No When was you last normal menstrual period? ________________________ h

8.Have you ever been under psychiatric care? ❒Yes ❒No When? _________________Why? _____________ 9.Have you had any recent blood work done? ❒Yes ❒No Where? ___________________________________ 10. Is there anything else you think the doctor should know?

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History of Cancer	YES	NO

History of Heart Troubles	YES	NO
History of Strokes	YES	NO
Bleeding Problems	YES	NO
Anesthesia Problems	YES	NO

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11. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons: (include where, when and why for each surgery)

SURGICAL OPERATIONS:

____

HOSPITALIZATIONS:

____

12. Have you been on any other cosmetic surgery consultations? If yes, with whom?

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