

MEDICAL HISTORY

Please answer all questions. If a question does not pertain to your medical history or the answer is no, please mark no in the area provided or mark N/A. Thank you.

NAME _____ DATE _____
DATE OF LAST PHYSICAL EXAM _____ DOCTOR _____

SURGERY (cosmetic and non-cosmetic surgery):
TYPE DATE COMPLICATIONS OR DIFFICULTIES

- 1. _____
- 2. _____
- 3. _____
- 4. _____

ADMISSIONS TO HOSPITAL:
REASON DATE COMPLICATIONS OR DIFFICULTIES

- 1. _____
- 2. _____
- 3. _____

MEDICATIONS (any drug or medicine) YOU TAKE NOW:
TYPE DOSAGE, AMOUNT IF KNOWN TAKEN HOW OFTEN

- 1. _____
- 2. _____
- 3. _____

CONSUMPTION OF THE FOLLOWING:

ASPIRIN _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____
ALCOHOL _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____
TOBACCO _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

HERBAL SUPPLEMENTS: YES ___ NO ___ LIST: _____
VITAMINS: YES ___ NO ___ LIST: _____

BLEEDING PROBLEMS:

DO YOU BRUISE OR BLEED EASILY? _____
(INVOLVING CUTS, TOOTH EXTRACTION, PREGNANCY, SURGERY)?
EXPLAIN:

DO YOU HAVE A FAMILY HISTORY OF BLEEDING PROBLEMS? _____

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA: YES ___ NO ___
EXPLAIN:

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES ___ NO ___

MEDICAL PROBLEMS OR CONDITIONS NOW UNDER TREATMENT BY A PHYSICIAN:

HAVE YOU EVER BEEN EXPOSED TO:

YES _____ NO _____ INTRAVENOUS DRUGS
YES _____ NO _____ INFECTIOUS DISEASES
YES _____ NO _____ TB
YES _____ NO _____ AIDS
YES _____ NO _____ HEPATITIS

HISTORY OF EPILEPSY OR MENTAL ILLNESS: YES _____ NO _____
EXPLAIN:

CHILDHOOD MEDICAL HISTORY:

HAD ALL KNOWN "BABY SHOTS"? YES _____ NO _____ UNCERTAIN _____
HAD POLIO IMMUNIZATION? YES _____ NO _____ UNCERTAIN _____
HAD RHEUMATIC FEVER? YES _____ NO _____ UNCERTAIN _____

FAMILY HISTORY:

ANY FAMILY HISTORY OR MEDICAL PROBLEMS OR ILLNESS? YES _____ NO _____

MOTHER _____ SISTER _____

FATHER _____ BROTHER _____

REVIEW OF SYSTEMS:

ANY SIGNIFICANT MEDICAL PROBLEMS WITH ANY OF THE FOLLOWING:

_____ HEAD, IF YES EXPLAIN:
_____ EYES, IF YES EXPLAIN:
_____ EARS, NOSE, THROAT, IF YES EXPLAIN:
_____ THYROID, IF YES EXPLAIN:
_____ LUNGS, IF YES EXPLAIN:
_____ HEART, IF YES EXPLAIN:
_____ BLOOD PRESSURE OR VESSELS, IF YES EXPLAIN:
_____ DIGESTIVE SYSTEM, IF YES EXPLAIN:
_____ LIVER, IF YES EXPLAIN:
_____ MUSCLES--BONES, IF YES EXPLAIN:
_____ REPRODUCTIVE ORGANS, IF YES EXPLAIN:
_____ KIDNEY'S--BLADDER, IF YES EXPLAIN:
_____ UNSIGHTLY SCARS, IF YES EXPLAIN:
_____ OTHER, IF YES EXPLAIN:
_____ DISEASE AFFECTING IMMUNE SYSTEM, IF YES EXPLAIN:

ALLERGIES:

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES _____ NO _____ PLEASE LIST.

ARE YOU PREGNANT? NO _____ YES _____

PREGNANCY HISTORY _____