



**II. PAST MEDICAL HISTORY**

a. What is your present: Height: \_\_\_\_\_ Weight: \_\_\_\_\_

b. Please indicate if you HAVE or have HAD any of the following medical problems:

	HAVE	HAD	COMMENTS/TREATMENT
High Blood Pressure			
Heart or Circulatory problems (eg. Chest pain/Heart Attack/ High cholesterol)			
Respiratory problems (eg. Asthma/Pneumonia/ Shortness of breath)			
Gastrointestinal Problems (eg. Ulcer/Hernia/Reflux)			
Genitounrinary Problems (eg. Voiding problems/ Menstrual problems/Impotence/Kidney stones)			
Endocrine/Immune Problems (eg. Thyroid problems/ Diabetes/HIV/AIDS/Lupus)			
Bleeding Problems (eg. Easy bruising/Clots/ Anemia)			
Musculoskeletal Problems (eg. Arthritis/Weakness/ Fibromyalgia/Limited mobility/Numbness/Tingling)			
Cancer (please indicate type)			
Eye Problems (eg. Dry eyes/Glaucoma/elevated intra ocular pressure/Tearing/ itchy eyes/ pigment changes around eyes)			
Nasal Problems (eg. Bleeding/Sinusitis/Difficulty breathing/Runny nose)			
Neurological/Emotional Problems (eg. Headaches/ Seizures/Depression)			

c. Please list any additional medical issues and any non-surgical hospitalizations or emergency room visits requiring treatment. (Please list additional problems on the last page.)

Year	Problem	Treating Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

**III. PAST SURGICAL HISTORY**

a. Have you ever had surgery, including *Plastic Surgery*? Yes No

b. If you have had Plastic Surgery, please rate your results:

Excellent Good Fair Poor

c. If your results were fair or poor, please describe briefly.

\_\_\_\_\_

\_\_\_\_\_

d. Please list all prior surgical procedures. (This includes removal of tonsils/appendix/gallbladder, LASIK surgery, wisdom tooth extraction, etc.) List additional surgeries on the last page.

Year	Procedure	Surgeon	Complications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

e. If you have had surgery, check type(s) of anesthesia you received and circle any problem(s).

- General Anesthesia    Nausea/Vomiting/Slow awakening/Difficult intubation/Other \_\_\_\_\_
- IV Sedation            Nausea/Vomiting/Slow awakening/Other \_\_\_\_\_
- Epidural/Spinal        Nausea/Vomiting/Insufficient/Bleeding/Headache/Other \_\_\_\_\_
- Block                    Insufficient /Prolonged/Systemic reaction Other \_\_\_\_\_  
(eg. Axillary, regional, etc.)
- Local                    Insufficient block/Heart palpitations/Systemic reaction/Other \_\_\_\_\_

**IV. MEDICATIONS**

a. Do you require antibiotics prior to surgery? Yes No

If so, why? \_\_\_\_\_

b. Do you take any medications including vitamins? Yes No

c. If so, please indicate.

	Name	Dose
<input type="checkbox"/> Blood pressure pills	_____	_____
<input type="checkbox"/> Water pills	_____	_____
<input type="checkbox"/> Blood thinners	_____	_____
<input type="checkbox"/> Steroids	_____	_____
<input type="checkbox"/> Insulin	_____	_____
<input type="checkbox"/> Hormone replacement therapy	_____	_____
<input type="checkbox"/> Vitamins (eg. B, C, E, K, etc.)	_____	_____

d. Please list ALL additional medications that you take. List additional medications on the last page.

Medication	Dose	Why?

e. Do you take any herbs, dietary supplements, or weight reduction products?  Yes  No  
If so, please circle.

Echinacea	Ephedra ( <i>Ma Huang</i> )	Feverfew	Garlic	Gingko
Ginseng	Goldenseal	Kave-kava	Licorice	METABO-life
St. John's Wort	Saw palmetto	Valerian		
Others _____				

f. Do you take aspirin or ibuprofen products?  Yes  No  
If so, please indicate.

- Aspirin (ASA/Bayer/Ecotrin/Excedrin/Fiorinal/etc)
- Ibuprofen (eg. Advil/Motrin/etc)
- Non-steroidal anti-inflammatories (eg. Aleve/Anapro/Daypro/Toradol/etc)
- Others \_\_\_\_\_

**V. ALLERGIES & SENSITIVITIES**

a. Medication Allergies or Sensitivities?  Yes  No  
If so, please indicate drug and circle reaction(s).

- Penicillin Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other \_\_\_\_\_
- Sulfa Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other \_\_\_\_\_
- Morphine Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other \_\_\_\_\_
- Codeine Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other \_\_\_\_\_

Other Medication(s)	Reaction
_____	Rash/Hives/Anaphylaxis/Swelling/Nausea/Vomiting/Other _____
_____	Rash/Hives/Anaphylaxis/Swelling/Nausea/Vomiting/Other _____

b. Environmental or Food Allergies?  Yes  No

c. Latex Allergies?  Yes  No

d. Tape or Adhesive Sensitivities?  Yes  No  
If so, please list type of tape or adhesive.

\_\_\_\_\_

**VI. SOCIAL HISTORY**

- a. Single    Married    Separated    Divorced    Widowed
- b. Children (birth years): \_\_\_\_\_
- c. Do you smoke?/Have you ever smoked?    Yes    No  
If yes, please indicate and circle appropriate reply:  
\_\_\_\_\_ Cig's or Packs/Day    \_\_\_\_\_ x Years    Quit \_\_\_\_\_ weeks/months/years ago
- d. Do you drink alcohol?    \_\_\_ times/Day    \_\_\_ times/Week    \_\_\_ Rarely    \_\_\_ Never
- f. Do you drink caffeinated beverages?    Yes    No    If yes: \_\_\_\_\_/Day
- g. Do you use any recreational drugs?    Yes    No

**VII. FAMILY HISTORY**

Do you have a family history of:		Relationship	Problem
Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Breast cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Other cancers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Bleeding problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Anesthesia problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Other problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

**VIII. ADDITIONAL INFORMATION**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

