

Medical History Questionnaire

Please Check the following as they pertain to your health history:

Bleeding Tendency

Anemia
 Low blood Count
How was it Treated: _____

 Sickle Cell Disorder
 Blood Transfusion
When: _____

Cancer

Type _____
Diagnosed when _____
Treatment _____

Diabetes

Insulin dependent? Non-
Insulin _____
Treatment _____
Diagnosed when _____
Physician Treating you

Eye/Ears/Nose/Mouth Problems

Cataracts
 Glaucoma
 Glasses/Contacts
 Hearing Aids
 Loose Teeth
 Dentures/Partials

Heart Disease

High Blood Pressure
 High Cholesterol
 History of Heart Attack
When _____
 Heart Surgery
When _____
 Chest Pains
Treatment _____
 Irregular Heart Beat
 Mitral Valve Prolapse
 Pacemaker
 History of Stroke
When _____
Physician Treating you

Kidney Disease

Trouble Urinating
 Kidney Stones
 Kidney Surgery

Liver Disease

Hepatitis A _____ B _____ C _____

Lung Disease

CPAP Machine
 Chronic Cough
 Asthma
Diagnosis When: _____
Treatment: _____
 Shortness of Breath
 Difficulty catching Breath
 Tuberculosis
 COPD
 Pulmonary Hypertension

Physician Treating you

Pain/Weakness

Where _____
Treatment _____
Physician Treating you

Psychiatric/Emotional Disorders

Depression
Treatment _____
 Anxiety
Treatment _____
Other: _____

Stomach Ulcers

Thyroid Problems

Hypothyroid
Treatment _____
 Hyperthyroid
Treatment _____

To the best of my knowledge the above information is correct.

Signature _____ Date _____

The Plastic Surgery Institute

Medical History Questionnaire

Name: _____ Date _____

1. Reason for you Office Visit today: _____

2. What is your Height: _____ Weight: _____

3. Please List Medications that you take including over the counter pills, prescriptions, vitamins, herbal supplements, and diet pills:

4. Please List Drug Allergies with reaction:

5. Please List ALL Surgeries that you have had:

6. Have you or a family member ever had complications from anesthesia? If YES, please explain:

7. To your knowledge do you have HIV/AIDS? _____ if deemed necessary would you agree to be tested for the HIV virus? YES _____ NO _____

Do you take Aspirin or Ibuprofen on a regular basis? YES _____ NO _____

Do you have excessive bleeding or bruising? YES _____ NO _____

Do you smoke or use any tobacco products? YES _____ How Much _____ NO _____

Are you Pregnant? YES _____ NO _____

Are you currently breast feeding? YES _____ NO _____

How Many Pregnancies have you had? _____

To the best of my knowledge the above information is correct.

Signature _____ Date _____