Austin-Weston Center for Cosmetic Surgery

HEALTH HISTORY

Name _____ Patient # _____

Address _____

_____ Age _____ Weight _____ Height _____

Telephone (H) _____ Pulse _____ Blood Pressure _____

(W) _____

(Cell) _____ Email _____

TO BE COMPLETED BY STAFF:

Today's Date: _____

Requests: Medical Clearance/ EKG/ Lab Work _____

Other _____

None ☐

Requested by _____

Final Review Date: _____ Reviewed by: _____

SOCIAL HISTORY:

Could you be pregnant? Yes ☐ No ☐ Do you smoke? Yes ☐ No ☐

Do you use alcohol? Yes ☐ No ☐ Have you ever smoked Yes ☐ No ☐

How much and how often? If yes, Number of packs per day?

Number of years?

FAMILY HISTORY:

With anesthesia &/or surgery, have **you or any family member** ever had problems with:

Nausea/vomiting	Yes ☐	No ☐	Who
Abnormal Bleeding	Yes ☐	No ☐	Who
Abnormal reaction to anesthesia	Yes ☐	No ☐	Who
Difficult Airway	Yes ☐	No ☐	Who

PERSONAL MEDICAL HISTORY:

Have **you** ever had or been treated for:

Cardiovascular:

High blood pressure	Yes ☐	No ☐
Heart attack /Chest pain	Yes ☐	No ☐
Murmurs/Mitral Valve prolapse/Valve problems	Yes ☐	No ☐
If yes, do you have Fatigue/Chest Pain/Shortness of breath	Yes ☐	No ☐
Palpitations/Arrhythmias	Yes ☐	No ☐
Coronary artery disease	Yes ☐	No ☐
Congestive heart failure	Yes ☐	No ☐
Blood clots	Yes ☐	No ☐
Shortness of breath when walking up flight of stairs	Yes ☐	No ☐
Swelling/discoloration of lower legs	Yes ☐	No ☐
Episodes of passing out	Yes ☐	No ☐
Pacemaker	Yes ☐	No ☐

Have you ever had

1. Cardiac surgery? Yes ☐ No ☐
   Type/date of surgery: _____
2. Angioplasty? Yes ☐ No ☐
   Date of procedure _____
3. Placement of Stent? Yes ☐ No ☐
4. Is the Stent drug eluting? Yes ☐ No ☐

<PersonalInfo.ChartNumber>

Austin-Weston Center for Cosmetic Surgery

HEALTH HISTORY

Respiratory:

Asthma	Yes ☐	No ☐
Have you ever been hospitalized as a result of asthma?	Yes ☐	No ☐
Bronchitis/Emphysema	Yes ☐	No ☐
Unexplained shortness of breath	Yes ☐	No ☐
History of pulmonary embolism	Yes ☐	No ☐
Treatment for or exposed to tuberculosis/Positive test	Yes ☐	No ☐
History of pneumonia	Yes ☐	No ☐
Have you had any lung surgery?	Yes ☐	No ☐
Do you have sleep apnea/use CPAP machine?	Yes ☐	No ☐
Do you snore?	Yes ☐	No ☐
Do you fall asleep easily and/or sometimes inappropriately?	Yes ☐	No ☐
Do you wake frequently during the night?	Yes ☐	No ☐

Gastrointestinal/Genitourinary:

Gastric reflux disease/Hiatal hernia	Yes ☐	No ☐
Frequent indigestion	Yes ☐	No ☐
Ulcer	Yes ☐	No ☐
Liver disorders	Yes ☐	No ☐
History of being jaundiced (skin turn yellow)	Yes ☐	No ☐
History of Hepatitis A, B or C (Please check)	Yes ☐	No ☐
Cirrhosis of liver	Yes ☐	No ☐
Kidney disorders/infections	Yes ☐	No ☐
Renal failure/dialysis	Yes ☐	No ☐
Frequent urinary tract infections/Kidney stones	Yes ☐	No ☐

Neurological:

Stroke/Cerebral vascular attack, CVA or TIA	Yes ☐	No ☐
Any deficits from stroke, CVA or TIA	Yes ☐	No ☐
Seizures/Epilepsy/Head trauma/Loss of consciousness	Yes ☐	No ☐
Neuromuscular disorders	Yes ☐	No ☐
Migraine headaches/Frequent headaches	Yes ☐	No ☐
Numbness/Weakness/Paralysis	Yes ☐	No ☐
History of depression/Emotional/Psychiatric problems or Eating Disorder	Yes ☐	No ☐

If yes, what medications are you taking? _____

Who prescribed your medication? _____

Endocrine:

Diabetes	Yes ☐	No ☐
Thyroid problems	Yes ☐	No ☐
Adrenal/Pituitary disease	Yes ☐	No ☐
Unexplained sudden weight loss/gain	Yes ☐	No ☐

How many? _____ lbs.

Hematology:

Anemia/Sickle cell disease/Blood disorders	Yes ☐	No ☐
History of blood transfusions	Yes ☐	No ☐
Hemophilia or bleeding disorder	Yes ☐	No ☐
Do you bruise easily?	Yes ☐	No ☐
History of HIV/AIDS	Yes ☐	No ☐

Musculoskeletal:

Arthritis	Yes ☐	No ☐
Osteoporosis	Yes ☐	No ☐
Scoliosis	Yes ☐	No ☐
Back/neck pain	Yes ☐	No ☐

Austin-Weston Center for Cosmetic Surgery

HEALTH HISTORY

Miscellaneous:

History of cancer (other than skin) Yes ☐ No ☐
Radiation : What area? Yes ☐ No ☐
Chemotherapy Yes ☐ No ☐
Autoimmune disorders Yes ☐ No ☐
Birth defects Yes ☐ No ☐
Use of marijuana/cocaine/heroin/other Yes ☐ No ☐
How much? How often?
Steroid use in the past 12 months Yes ☐ No ☐
Any major accident/injuries Yes ☐ No ☐
Do you exercise regularly? Yes ☐ No ☐
How often? What kind?
History of fever blisters/cold sores/shingles Yes ☐ No ☐
Do you use Retin A? Yes ☐ No ☐
Have you had a facial peel in the last month? Yes ☐ No ☐

If you have answered **Yes** to any of the above questions, please explain:

_____

_____

_____

Dental: Condition of teeth: Missing ☐ Chipped ☐ Caps ☐
Dentures: Upper ☐ Lower ☐
Bridges/partials: Permanent ☐ Removable ☐
Veneers/Bonding ☐ Location

Allergies: NONE: ☐ or

List allergies and **reactions** to medications, eggs, soy, other foods, latex or environment:

ALLERGY	REACTION	ALLERGY	REACTION

Medications: **NONE:** ☐ or

Prescription medications with dose and time taken *(include contraceptives and hormones):*
If you have additional prescription medications, please use attached sheet.

MEDICATION & DOSAGE	WHEN TAKEN	WHY TAKEN

Austin-Weston Center for Cosmetic Surgery

HEALTH HISTORY

Over the counter medications *(aspirin, sleeping pills, diet pills, herbal supplements, etc.):*

OVER THE COUNTER MEDICATION & DOSAGE NONE: ☐ or		

Please list any past hospitalizations and/all surgeries with approximate dates: **NONE:** ☐

Please list your primary care physician along with any other specialty physicians whose care you are under *(include phone number)*: **NONE:** ☐

"The information I have provided is accurate to the best of my knowledge."

Signature: _____ Date: _____

Doctor's Initials: _____