MEDICAL & SURGICAL HISTORY 3.5.2018

Patient Name: _____ DOB: _____ Age:_____ Circle: M F
Referral Source: _____ May we thank them? Y N ☺
What is your interest in our practice?_____

Please mark "Yes" if you have ever had the following conditions, now or in the past, and describe where indicated. If not, please mark "No." All answers are confidential.

Medical History

Condition	Yes	No	Describe	Condition	Yes	No	Describe
Diabetes				Kidney disease (list)	→		
→ insulin dependent?				Ulcers (list type)	→	→	
Glaucoma				Colitis			
Dry eyes				Cancer (list type)			
Other eye problems:	→	→		Hepatitis A			
Heart attack				Hepatitis B			
Irregular heart beat				Hepatitis C			
Angina (chest pain)				HIV			
Mitral valve prolapse				AIDS			
Heart failure				Bleeding disorder (list)	→	→	
Other heart issues (list)	→	→		Blood transfusion (year?)			Year:
Stroke or TIA				Anemia			
High blood pressure				Herniated disc (level)			Level:
Asthma				Anesthesia reactions (list)			
Tuberculosis				Thyroid disease (list type)			
Chronic cough				Depression/ Anxiety			
Emphysema				Mental health conditions (list)			
Shortness of breath				Drug addiction			
Sleep apnea				→Sober? (How long?)			
Sleep apnea, on CPAP				Alcohol addiction			
Seizures/Epilepsy				→Sober? (How long?)			
Multiple sclerosis				*Labia/Vaginal Interest only*			
Neurologic disorders				Genital Herpes	**Yes**	**No**	
Bell's Palsy				Genital Warts	**Yes**	**No**	
Shingles				History of HPV	**Yes**	**No**	
Cold sores ever				**Anything else, list:**			
Myasthenia gravis							
Currently pregnant or breastfeeding?	**Yes**	**No**	**N/A**				

Medications

Plastic Surgery Associates & Allegro MedSpa
4625 Quigg Drive, Santa Rosa, CA 95409
Phone: (707) 537-2111; Fax (707) 537-2119

Office Use Only DATE: _____

Please list <u>all</u> medications you take below (prescription and nonprescription medications, including aspirin, vitamins, supplements, and herbal preparations). Indicate the dosage and the reason for taking each medication.

Medication:	Dosage	Condition or reason for medication
I take no routine or as needed medications: ☐		

Allergies

Do you have allergies to medication?	Yes	No	NonMedication allergies?	Yes	No
If yes, please list below:	**Type of reaction:**		**If yes, please list below:**	**Type of reaction:**	

Surgical History

List all surgeries you have had, including all plastic surgery.			
Type of Operation	**Year**	**Place**	**Surgeon**

Family History

Condition:	Yes	No	Condition:	Yes	No
Heart Disease			Malignant hyperthermia from anesthesia*		
Stroke					
High Blood Pressure			Any other severe anesthesia reactions?*		
Diabetes					
Bleeding or clotting disorder					
*Unknown as I am adopted: ☐			*Please describe details in the space provided. Thanks!		

Social History

Occupation: (please list)								
Marital Status: (please circle)	**Single**	**Partnered**	**Married**	**Separated**	**Divorced**	**Widowed**		
Do you have any children?	**Yes**	**No**	**# of sons:**	**ages:**				
			# of daughters:	**ages:**				
Do you take any recreational drugs (marijuana, cocaine, methamphetamine, ecstasy, heroin, etc.)?	**Yes**	**No**	**Never**					
Have you ever taken IV recreational drugs?	**Yes**	**No**	**Never**					
If yes, when?		**And what?**						
Do you smoke tobacco now?	**Yes**	**No**	**Were you ever a smoker?**	**Yes**	**No**			
If you quit smoking, what age did you quit?		**How many packs a day do you /did you used to smoke?**		**How many years?**				
How much alcohol do you drink per week (such as glasses of wine per week)?								

Other Health Providers

Please list all medical providers you see, starting with your primary care doctor.

Specialty	**Doctor's name**	**City and State**
Primary care		

Please indicate your height and weight. Thank you!

My height is___feet ___inches.	**My weight is _____pounds.**

Skin History

Condition:	**Yes**	**No**	**Condition:**	**Yes**	**No**
History of Keloid Scarring?			**ANY** dermal piercings?		
History of Melasma?			Frequent Sun Exposure?		
History of Skin Cancer?			Do you routinely use Sunscreen?		
History of Cystic Acne?					
History of Accutane? *If yes, in last six months?*			Other Skin Conditions:		
History of Cold Sores **** At Any Time****					

If you're considering a treatment to the face, please indicate previous treatments:

Type of Treatment	Yes	No	Type of Treatment	Yes	No
Laser Procedure			Botox		
Intense Pulse Light (IPL)			Filler		
TCA Peel			Waxing		
Glycolic/other chemical peel			Facials		
Microdermabrasion			Other:		

Other than the services we are already providing for you, what additional services would you like to learn about? Please check all that apply.

□ Skin consultation □ Make-up □ Chemical Peels □ Facial redness □ Brown spots/age spots/freckles □ Botox □ Filler □ Cheek fullness □ Thin lips □ Unwanted Hair □ Length/Fullness of Eyelashes	□ Facial fullness/drooping □ Facial fine lines/wrinkles □ Drooping brow or eyelids □ Neck wrinkles/drooping □ Décolletage (Chest) texture or fine lines □ Body contouring □ Abdominal contouring □ Scar therapy	□ Surgical consultation for face □ Surgical consultation for body □ Surgical consultation for nose □ Surgical consultation for breast □ Surgical consult for labiaplasty or vaginoplasty May our coordinator contact you to discuss these services? □ **Yes** □ **No**

Please list all family members and their relationship to you, along with any friends, with whom we can discuss your care:

_____ _____

_____ _____

Signature of Patient/Guardian/Parent of Minor Patient **Date**

Thank you for all the time and thought you put into filling out this form!