THE CENTER FOR COSMETIC SURGERY
HEALTH HISTORY--2/2016

Name:_____**DOB:** _____ **Height:** _____**Weight:**_____
Pregnancies_____**Births**_____ **Last Menstrual Period** _____ ____**Menopause** Y / N--If yes, year?_____
Medications (prescription, hormones, over the counters and supplements): **Dosage:** **Frequency:**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Drug Allergies: Y / N (If yes, what drugs and reactions): _____
_____
_____

Latex Allergy: Y / N **Reaction?** _____**Food Allergies:** Y / N **What Foods?** _____ **Soy or Peanut Allergy:** Y / N
Do you smoke or use nicotine: Y / N If yes: _____ # per day **Alcohol Use:** # of Drinks _____ per _____
If you quit nicotine, how long ago? _____ **Recreational Drug Use:** Y / N --Substances _____
List ALL previous Surgeries with Approximate Dates (AND any anesthesia complications?): **Last Mammogram:** _____
_____
_____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES? Circle ALL that Apply:

HEART PROBLEMS: Y / N
Examples: Hypertension, Heart Attack, Coronary Artery Disease, Congestive Heart Failure, Pacemaker, Stent

LUNG PROBLEMS: Y / N
Examples: Asthma, COPD, Emphysema, Pulmonary Embolism/Blood Clots, Tuberculosis, Sleep Apnea/CPAP

ENDOCRINE PROBLEMS: Y / N
Examples: Diabetes (Type I or II), Thyroid Disorder, Cancer(s), Swollen Leg(s), Thrombocytopenia

KIDNEY PROBLEMS: Y / N
Examples: Frequent Urinary Tract Infections, Kidney Stones

GASTROINTESTINAL PROBLEMS: Y/N
Examples: Reflux, Irritable Bowel Syndrome, Crohn's Disease, Ulcers, Colitis, Hernia

LIVER PROBLEMS: Y / N
Examples: Hepatitis, Jaundice, Cirrhosis, Alcoholism

NEUROLOGICAL PROBLEMS: Y / N
Examples: Epilepsy, Seizures, Stroke, Multiple Sclerosis, Cerebral Palsy, ALS, Parkinson's, Raynaud's

MUSCULOSKELETAL PROBLEMS: Y / N
Examples: Neck/Back problems, Rheumatoid Arthritis, Osteoarthritis, Artificial Joints, TMJ

PSYCHOLOGICAL HISTORY: Y / N
Examples: Depression, Anxiety, Chronic Pain, Alcohol/Drug Misuse, Eating Disorder, Domestic Violence

OTHER DISEASES/RECENT ILLNESS: _____

FAMILY HISTORY (Specify who--your parents, siblings or children):
Diabetes: Y / N _____
Cancers (specify type): Y / N _____
Bleeding Problems/Blood Clots: Y / N _____
Anesthesia Problems (specify): Y / N _____

_____ _____
Patient Signature Date

_____ _____
RN Signature Date

_____ _____
MD Signature Date