THE CENTER FOR COSMETIC SURGERY
HEALTH HISTORY--2018

NAME:_____**DOB:** _____ **Height:** _____**Weight:**_____
Pregnancies_____**Births**_____ **Last Menstrual Period** _____ **Menopause** Y / N--If yes, year?_____
ALL Medications (Prescriptions-Over the counter-Hormones-Supplements): **Reason & Dosage:** **Frequency:**

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

Drug Allergies: Y / N (IF yes, what drugs and what reaction): _____
_____
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 – What/When: _____
List ALL Previous Surgeries/Reason and Dates (AND any anesthesia problems?): **Last Mammogram:** _____
_____
_____
_____

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

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

LUNG PROBLEMS: Y / N
Examples: Asthma, COPD, Emphysema, Tuberculosis, Sleep Apnea/CPAP

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

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

GASTROINTESTINAL PROBLEMS: Y/N
Examples: Reflux/GERD, Chronic Inflammatory Bowel Disease, Crohn's Disease, Ulcer, Colitis, Hernia

LIVER PROBLEMS: Y / N
Examples: Hepatitis, HIV, Jaundice, Cirrhosis, Alcoholism, Fatty Liver Disease

NEUROLOGICAL PROBLEMS: Y / N
Examples: Epilepsy, Seizures, 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 Rehab, Eating Disorders, Domestic Violence

HEMATOLOGIC HISTORY: Y / N
Examples: DVT/PE, Thrombocytopenia, Bleeding/Clotting Disorder, Factor V, von Willebrand's, Hemophilia

ANY OTHERS--NOT LISTED ABOVE:_____

FAMILY HISTORY (Specify WHO--IF YOUR parents, siblings or children-primary relatives):
Diabetes (specify-who/type): Y / N _____
Cancers (specify-who/type): Y / N _____
DVT or PE Blood Clots (specify): Y / N _____
Anesthesia Reactions (specify): Y / N _____

_____ _____
Patient Signature Date

_____ _____
RN Signature Date

_____ _____
MD Signature Date