Center for Cosmetic Surgery

NAME:______________________________________**Age:**_____**Sex: F M** **Height**__________**Weight**_______________
Referred by:___________________________________**Primary Care Doctor/City**______________________________________
REASON FOR VISIT TODAY: ____
Due to an injury? Y N On the job injury? Y N Auto accident? Y N Date of injury/accident: _________________

PAST MEDICAL HISTORY: (Have you ever had any of the following medical conditions?)

Condition			Condition		
High blood pressure	Y	N	Stomach ulcer or gastritis	Y	N
Heart attack or congestive heart failure	Y	N	Hepatitis or other disorder of the liver	Y	N
Heart murmur or heart valve disorder	Y	N	Kidney disease or renal failure	Y	N
Asthma, bronchitis, COPD or lung disease	Y	N	History of blood clots in the veins of your legs	Y	N
Stroke, TIA or paralysis	Y	N	Anemia or any other blood disorder	Y	N
Diabetes or thyroid disorder	Y	N	Transfusion of blood or blood products	Y	N
Autoimmune disease	Y	N	Glaucoma or other eye disorder	Y	N
Arthritis or degenerative joint disease	Y	N	Seizure disorder	Y	N
Cancer (**What type?**) ___________________	Y	N	History of any psychiatric disorder	Y	N
			Do you have any significant barriers to learning?	Y	N

Any other medical problems? (Be specific): ____

Have you had a mammogram? Y N **Where?**________________________**When?** ___________________

PAST SURGICAL HISTORY: (List ALL previous surgeries by date including any cosmetic surgery procedures.)

SURGERY	***DATE***	***ANY PROBLEMS WITH THE SURGERY OR ANESTHETIC?***

ALLERGIES: (Reaction to any medication, drug, or anesthetic)

ALLERGIC TO:	***REACTIONS***

MEDICATIONS: (Prescription, herbal, and over-the-counter)

MEDICATIONS:	***DOSE & FREQUENCY***

Preferred pharmacy (Name, City &Telephone #): ____

SOCIAL HISTORY:

Marital status: *S M D W* Number of children: _____ Children at home: ____ Hobbies: ___________________________________

Do you use tobacco? ***Never In the past Occasionally Regularly*** Amount/day: ____________ Number of years: ____________

Do you drink alcohol? ***Never In the past Occasionally Regularly*** Amount/day: ____________ Number of years: ____________

FAMILY HISTORY: (Any history of the following conditions in a blood relative? Which family members?)

Condition			Family members	Condition			Family members
High blood pressure	Y	N		Heart disease	Y	N	
Diabetes	Y	N		Stroke	Y	N	
Cancer (***What type?***)	Y	N		Bleeding disorder	Y	N	

REVIEW OF SYSTEMS: (Have you recently experienced or do you currently experience any of the following symptoms?)

Symptom			Symptom		
Recent weight loss or easy fatigability	Y	N	Pain or burning when you urinate	Y	N
Fever, chills, or night sweats	Y	N	Pain in your extremities or major joints	Y	N
Change in vision or temporary loss of vision	Y	N	Slow wound healing or excessive scaring	Y	N
Excessive tearing or excessively dry eyes	Y	N	Change in size or color of a mole or other growth	Y	N
Irregular heart rate or palpitations	Y	N	New lumps or discomfort in your breast	Y	N
Tightness, pressure or pain in your chest	Y	N	Dizziness, light-headedness or faintness	Y	N
Swelling of your feet or ankles	Y	N	Weakness in any extremity	Y	N
A recent cold, flu or pneumonia	Y	N	Any unusual stress in your life at this time	Y	N
Wheezing or shortness of breath	Y	N	Any chance that you may be pregnant	Y	N
Heartburn or reflux	Y	N	Excessive or prolonged bleeding when cut	Y	N
Frequent loose stools or constipation	Y	N	Any known deficiency of your immune system	Y	N
Blood in your stool or urine	Y	N	Allergy or reaction to Latex	Y	N

Patient Signature: ___________________________________ **Date:** _______________ Physician Signature: ________________________