



## COSMETIC PATIENT HEALTH HISTORY

Date _____		Referred By _____	
Patient Name _____			
Address _____			
City _____		State _____	Zip _____
Phone (home) _____		Phone (work) _____	E-mail _____
Date of Birth _____		Age _____	Occupation _____
Marital Status (circle one) Single / Married / Separated / Divorced / Widow			
Emergency Contact _____		Phone _____	Relationship _____
Family Physician _____		Phone _____	City / State _____
Do we have permission to obtain additional health information from your family physician? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have any allergies or sensitivities? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list _____			
Are you currently taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list _____			
_____			
Are you currently taking aspirin, ibuprofen, minerals, herbs, nutritional supplements, birth control pills or sexual performance drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please list. _____			
_____			
<b>Please check the procedure(s) in which you are interested.</b>			
<input type="checkbox"/> Body Liposuction	<input type="checkbox"/> Otoplasty (ear pinning)	<input type="checkbox"/> Skin Care Products	<input type="checkbox"/> Laser Vein Removal
<input type="checkbox"/> Face Liposuction	<input type="checkbox"/> Rhinoplasty (nose)	<input type="checkbox"/> Facials	<input type="checkbox"/> Laser Hair Removal
<input type="checkbox"/> Blepharoplasty (eyes)	<input type="checkbox"/> Repair Torn Earlobes	<input type="checkbox"/> Glycolic peels	<input type="checkbox"/> IPL
<input type="checkbox"/> Brow Lift	<input type="checkbox"/> Sculptra Injection	<input type="checkbox"/> TCA Peels	<input type="checkbox"/> Other
<input type="checkbox"/> Quicklift™	<input type="checkbox"/> Restylane Injection	<input type="checkbox"/> CO2 Laser Resurfacing	
<input type="checkbox"/> Full Face Lift	<input type="checkbox"/> Botox Injection	<input type="checkbox"/> Thermage®	
Do you desire improvement in function as well as aesthetics? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain _____			
_____			
When did you first consider cosmetic surgery? _____			
Have you consulted with another doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Have you pursued other alternatives?

Yes  No

If yes, please specify \_\_\_\_\_

Have you had previous cosmetic, plastic or reconstructive surgery?

Yes  No

What type of surgery? \_\_\_\_\_

Date \_\_\_\_\_

By whom? \_\_\_\_\_

Were there aspects of your surgery that did not meet your expectations?

Yes  No

If yes, please specify \_\_\_\_\_

Has any family member or close friend had cosmetic, plastic or reconstructive surgery?

Yes  No

What type of surgery? \_\_\_\_\_

Date \_\_\_\_\_

By whom? \_\_\_\_\_

Do you feel he or she could have obtained better results?

Yes  No

If yes, please explain \_\_\_\_\_

Have you ever had any other type of surgery?

Yes  No

Type of surgery \_\_\_\_\_

Date \_\_\_\_\_

Type of surgery \_\_\_\_\_

Date \_\_\_\_\_

Type of surgery \_\_\_\_\_

Date \_\_\_\_\_

Did you experience any complications?

Yes  No

If yes, please specify \_\_\_\_\_

Have you ever had local anesthesia (Novocain, Xylocaine, etc) by a dentist or doctor?

Yes  No

Have you ever experienced an adverse reaction to anesthesia?

Yes  No

If yes, please describe the type of reaction \_\_\_\_\_

When was your last physical examination? \_\_\_\_\_

Do you have a history of bleeding?

Yes  No

If yes, please specify \_\_\_\_\_

Bleeding from the nose

Blood in urine

Vomiting blood

Other \_\_\_\_\_

Bleeding from the rectum

Coughing up blood

Bleeding from dental procedures

Please explain and list any other bleeding problems. \_\_\_\_\_

Please continue to the reverse side of this page

**WOMEN**

Is there a history of breast cancer in your family?

 Yes  No

If yes, please specify \_\_\_\_\_

Is your menstrual cycle often irregular?

 Yes  No

Do you have heavy menstrual periods?

 Yes  No

When was your last period? \_\_\_\_\_

How many tampons/pads do you use per day? \_\_\_\_\_

How many days does your period last? \_\_\_\_\_

Are you currently or trying to get pregnant?  Yes  No

Do you have a history of gynecological problems?

 Yes  No

If yes, please specify \_\_\_\_\_

**MEN**

Have you ever had prostate problems?

 Yes  No

Do you use sexual performance drugs such as Viagra, Levitra, Cialis, etc.?

 Yes  No**PLEASE CHECK ALL THAT APPLY TO YOU CURRENTLY OR IN THE PAST.**

Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	High / Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nasal Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision / Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decreased circulation (fingers/toes)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Irritations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gall Bladder Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/Aids	<input type="checkbox"/> Yes <input type="checkbox"/> No
Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Severe Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Paralysis/Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Autoimmune Disease (Lupus, MS)	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered yes to any of the above, please explain and list medications that are being used to treat the condition

Do you or any family members have the following (please indicate relationship)?

Heart trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____
Excessive bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____
Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____
Excessive bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____
Unfavorable/wide scarring	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____
Delayed or poor healing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____
Psychiatric or nerve problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____
Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____
Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____

Are you frequently sick or ill?  Yes  No

Have you ever taken hormone or thyroid medications?  Yes  No

Are you double jointed?  Yes  No

Can you touch your tongue to your nose or your thumb to your forearm?  Yes  No

Do you have a tendency to faint or pass out?  Yes  No

Do you smoke cigarettes?  Yes  No

Do you drink more than 6 cups of coffee per day?  Yes  No

Do you normally have more than 2 drinks of alcohol per day?  Yes  No

Have you ever been under the care of a psychologist or psychiatrist?  Yes  No

If yes, please explain. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you understand that medical and surgical treatments cannot promise  
or guarantee a good outcome?  Yes  No

Do you understand that all risks and complications cannot be prevented  
when a surgical procedure is performed?  Yes  No

*Thank you.*

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_