PERSONAL HEALTH HISTORY

NAME:____HEIGHT:_______________WEIGHT: ______________

PLEASE BE EXTREMELY ACCURATE WHEN ANSWERING ALL MEDICAL QUESTIONS. YOUR ANSWERS COULD HAVE AN EFFECT ON YOUR POST-OP RECOVERY AND FINAL RESULT!

Drug Allergies: ____

Are you Allergic to Latex? ❑**Y** ❑ **N** Other Allergies (*i.e. iodine, tape, skin sensitivity*): ___________________________

Present Medications: (Include herbs, vitamins, over-the-counter meds, hormones and contraceptives. _________________________

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Have you ever had surgery (Include Plastic/Cosmetic surgery)**?** ❑ Y ❑ N Please list the surgeon, procedure and year

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Have you had any reactions to anesthesia? ❑ Y ❑ N If yes, please describe____

Please indicate which conditions(s) you have by checking the box (es):

- ❑ Abnormal Scarring
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Diabetes
- ❑ Glaucoma
- ❑ Heart Problems
- ❑ Hemangiomas
- ❑ Hemophilia
- ❑ Hepatitis (type)____________
- ❑ High Blood Pressure
- ❑ Hyperpigmentation
- ❑ Keloid
- ❑ Kidney Disease
- ❑ Lupus
- ❑ Port Wine Stain
- ❑ Postive HIV Test
- ❑ Respiratory Problems
- ❑ Restless Leg Syndrome
- ❑ Rheumatic Fever
- ❑ Scleroderma
- ❑ Seizures
- ❑ Sexually Transmitted Diseases
- ❑ Shortness of Breath
- ❑ Thyroid

❑ Have you ever been under the care of a psychiatrist/psychologist? ❑ Y ❑ N When_____________________________

When was your last physical examination?__________________Who was the physician?______________________________

Do you wear contact lenses? ❑ Y ❑ N Do you wear dentures? ❑ Y ❑ N

Have you ever had a mammogram? ❑ Y ❑ N When?_____________________Where? ___________________________

Personal or Family History of Clotting Disorders? ❑ Y ❑ N

*Do you smoke? ❑ Y ❑ N Have you ever smoked? ❑ Y ❑ N If yes, for how long? ______________When_______________

*When did you quit smoking? _________ Do you drink alcohol? ❑ Y ❑ N If yes, how much? ____________

*Do you take aspirin, Motrin, Nuprin, Ecotrin or Advil on a regular basis? ________if so, how much? _____________________

SIGN____ DATE _______________