

Please help us assure you the highest quality of care by answering carefully.

**DEMOGRAPHICS**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SSN: XXX - XX - \_\_\_\_\_ Sex: \_\_\_\_\_  
Date of Surgery: \_\_\_\_\_

**TODAY'S VISIT**

Age on this visit: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Personal Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Date of last exam: \_\_\_\_\_ Results: \_\_\_\_\_  
Whom may we thank for this referral?: \_\_\_\_\_  
This consultation is to discuss: \_\_\_\_\_

**CURRENT MEDICATIONS**

1. Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Last Time Taken: \_\_\_\_\_  
2. Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Last Time Taken: \_\_\_\_\_  
3. Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Last Time Taken: \_\_\_\_\_  
4. Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Last Time Taken: \_\_\_\_\_  
5. Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Last Time Taken: \_\_\_\_\_

**MEDICAL HISTORY**

*Please check appropriate box(es) if you currently have, or have had, any of the following:*

<input type="checkbox"/> Prolonged bleeding when cut	<input type="checkbox"/> Blood disorders (anemia, etc.)	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Immune disorders
<input type="checkbox"/> Fainting or blackout episodes	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Heart murmur
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Herpes, fever blisters	<input type="checkbox"/> Lung/respiratory problems	<input type="checkbox"/> Heart valve disorder
<input type="checkbox"/> Ulcer disease	<input type="checkbox"/> Skin disorders	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Heart disease and/or heart attack	<input type="checkbox"/> Eyes: burning, dryness, itching	<input type="checkbox"/> Swelling of ankles	
<input type="checkbox"/> Irregular heart beat, palpitations	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	

Are you pregnant?  NO  YES  
Date of last menstrual period: \_\_\_\_\_  
How many pregnancies: \_\_\_\_\_  
If you answered yes to any of the above, please explain: \_\_\_\_\_

**SURGICAL HISTORY**

*Previous procedures and when they occurred:*

**COSMETIC:**

- Eye: \_\_\_\_\_
- Ear: \_\_\_\_\_
- Nose: \_\_\_\_\_
- Face: \_\_\_\_\_
- Breast: \_\_\_\_\_
- Body Contouring: \_\_\_\_\_

**OTHER:**

- Gallbladder: \_\_\_\_\_
- Appendix: \_\_\_\_\_
- OB/GYN: \_\_\_\_\_
- Sinus/Nose: \_\_\_\_\_
- Abdominal: \_\_\_\_\_
- Breast: \_\_\_\_\_

- Tonsils: \_\_\_\_\_
- Eyes: \_\_\_\_\_
- Heart: \_\_\_\_\_
- Orthopedic: \_\_\_\_\_
- Hysterectomy: \_\_\_\_\_
- Other: \_\_\_\_\_

Have you or anyone in your family had a reaction to general anesthesia?  NO  YES

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

**SCARRING, BLEEDING AND TRANSFUSIONS**

Have you formed excessive or unsatisfactory scars in the past?  NO  YES

If yes, give locations: \_\_\_\_\_

Have you taken aspirin, anti-inflammatory medications or blood thinners within the past two weeks?  NO  YES

If yes, please list: \_\_\_\_\_

Have you had any prolonged bleeding when cut and/or is it in your family history?  NO  YES

Have you had a blood transfusion?  NO  YES If yes, give date(s): \_\_\_\_\_

Have you experienced a reaction to a transfusion?  NO  YES If yes, please describe: \_\_\_\_\_

**ALLERGIES**

Medication(s) and type of reaction: \_\_\_\_\_

\_\_\_\_\_

Tape/Type: \_\_\_\_\_ Soap(s): \_\_\_\_\_

Food(s): \_\_\_\_\_

**PERSONAL HEALTH HABITS**

Do you now smoke, or have you ever smoked?  NO  YES If yes, how many packs per day? \_\_\_\_\_

Have you quit?  NO  YES If yes, when? \_\_\_\_\_

Do you drink alcohol?  NO  YES If yes, how often? \_\_\_\_\_

Do you use any non-prescription medications or drugs not already listed?  NO  YES If yes, please list: \_\_\_\_\_

\_\_\_\_\_

Do you use any diet medicines?  NO  YES If yes, please list: \_\_\_\_\_

Do you use St. John's Wort?  NO  YES If yes, please list the dosage and times you take it: \_\_\_\_\_

Do you take Ginseng?  NO  YES If yes, please list the dosage and times you take it: \_\_\_\_\_

Do you take Omega 3 supplements?  NO  YES If yes, please list the dosage and times you take it: \_\_\_\_\_

Do you take any other herbal medications?  NO  YES If yes, please list: \_\_\_\_\_

Completed by: \_\_\_\_\_

Reviewed with patient by/Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_