Medical Questionnaire

Name: _____ **Date:** _____

What is the reason for your visit?

Are there any facial plastic procedures you wish to discuss?

OPERATIVE HISTORY

List ALL operative procedures including minor surgery, procedures done under local anesthesia and pregnancies:

Date(s) **Procedure(s)**

Have you ever had a blood transfusion? _____ **When?** _____
Date of last medical check-up _____ **Result:** _____
Date of last Chest X-ray _____ **Result:** _____
Date of last electrocardiogram (EKG) _____ **Result:** _____
Do you smoke? Yes No How much? _____ **How long?** _____
Do you drink alcohol? Yes No How much? _____ **How long?** _____
Do you use any recreational drugs? Yes No Which ones _____
Are you on a special diet? Yes No What kind? _____

How many children do you have? _____
List athletic activities _____
List hobbies _____

List ALL drug allergies or adverse reactions: _____
_____
_____

List environmental, contact and food allergies: _____
_____
_____

List ALL drugs and dosages (prescription, non-prescription, vitamins, health supplements) _____
_____
_____
_____
_____

Do you take aspirin (ASA) or ASA-containing medications, motrin/advil or ibuprofen-containing medications? Which ones _____
_____

Are you under the care of a doctor for any other problems at this time? _____
_____

Have you ever been dissatisfied with the treatment you received from a doctor or dentist? _____
_____

Please check if any of the following apply to you:

	Yes
Radiation Therapy (eg. for acne, tonsils, or cancer)	[ ]
Accutane treatment for acne	[ ]
Skin, hair or nail diseases	[ ]
Facial operations	[ ]
Excessive sun exposure/sunburns	[ ]
Bleeding or bruising problems	[ ]
Eye problems, eyeglasses, or contacts	[ ]
Nose operations, Nose injuries	[ ]
Nose pain, bleeding, discharge	[ ]
Nose obstruction, snoring	[ ]
Nose allergies, polyps, loss of smell	[ ]
Sinusitis, post nasal drip	[ ]
Desire to change nasal shape	[ ]
Teeth, gum, mouth problems	[ ]
Dentures, Orthodontic appliances	[ ]
Noisy breathing, sleep problems, sleep apnea	[ ]
Shortness of breath, chest pain, angina	[ ]
Cough with blood or sputum	[ ]
Asthma, tuberculosis, bronchitis	[ ]
Marked weight ro appetite change	[ ]
Neck operations, masses, thyroid disease	[ ]
Trouble swallowing, hiatus hernia	[ ]
Ear pain, bleeding, discharge	[ ]
Ear operations, infections	[ ]
Hearing loss, use of hearing aids	[ ]
Ringing in ears, tinnitus	[ ]
Dizziness, vertigo	[ ]

Past Health And Family History

Check all medical conditions that you or your immediate family members (brothers, sisters, children, parents, grandparents) have now or have had in the past.

	Yourself	Family Members
Allergies, asthma, eczema, hay fever	[ ]	[ ]
Anesthesia reaction	[ ]	[ ]
Bleeding problem, anemia	[ ]	[ ]
Heart disease, heart murmurs	[ ]	[ ]
Heart attack, angina	[ ]	[ ]
Rheumatic fever	[ ]	[ ]
High or low blood pressure	[ ]	[ ]
High cholesterol, triglycerides	[ ]	[ ]
Stomach or ulcer disease	[ ]	[ ]
Liver, spleen disease, Jaundice or hepatitis	[ ]	[ ]
Kidney disease or stones, bladder disease	[ ]	[ ]
Venereal disease or genital disease	[ ]	[ ]
Gynecologic disorders (female)	[ ]	[ ]
HIV Risk, HIV positive, AIDS	[ ]	[ ]
Diabetes, thyroid, endocrine disorders	[ ]	[ ]
Blood, or lymph gland disorders	[ ]	[ ]
Cancer, breast cancer, skin cancer	[ ]	[ ]
Growths, cysts, tumors	[ ]	[ ]
Muscle, bone, or joint disorders	[ ]	[ ]
Nervous system disorders	[ ]	[ ]
Strokes, seizures	[ ]	[ ]
Migraines, Headaches	[ ]	[ ]
Psychological disorders	[ ]	[ ]
Alcohol or drug problems	[ ]	[ ]

Patient Signature:_____ **Physician Signature:**_____