Advanced Surgical Arts Center
MEDICAL HISTORY

Name:____ DOB:________ Height:______ Weight:______

What brings you to our office? Please check all the boxes you are interested in.

☐ Breasts ☐ Liposuction ☐ Abdominoplasty ☐ Face/Neck ☐ Eyelid Surgery ☐ Arms ☐ Cellulite Reduction ☐ Laser Resurfacing

☐ Botox ☐ Dermal Fillers ☐ Double Chin ☐ Sclerotherapy ☐ CoolSculpting ☐ Skin Care ☐ Hair Removal

☐ Other ____

REVIEW OF SYSTEMS: Do you have or have you had any of the following? (Please check yes or no)

General

Fever	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Blood transfusion	☐ Yes	☐ No
Cancer	☐ Yes	☐ No

Eyes

Eye surgery	☐ Yes	☐ No
Dry eyes	☐ Yes	☐ No
Glasses/contacts	☐ Yes	☐ No
Blindness	☐ Yes	☐ No
Blurry/double vision	☐ Yes	☐ No

Ear/Nose/Throat

Deafness	☐ Yes	☐ No
Sinus trouble	☐ Yes	☐ No
Hoarseness	☐ Yes	☐ No
Allergies	☐ Yes	☐ No

Respiratory

Asthma	☐ Yes	☐ No
Breathing problems	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No

Musculoskeletal

Arthritis	☐ Yes	☐ No
Neck/back problems	☐ Yes	☐ No
Stiffness	☐ Yes	☐ No
Atrophy	☐ Yes	☐ No

Neurological

Neuromuscular disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Seizure	☐ Yes	☐ No
Multiple sclerosis	☐ Yes	☐ No
Visual/balance problems	☐ Yes	☐ No

Allergies

Latex allergy	☐ Yes	☐ No
Drug allergy	☐ Yes	☐ No

Hematologic/Lymphatic

Excessive bleeding	☐ Yes	☐ No
Lymph node enlargement	☐ Yes	☐ No
History of blood clots	☐ Yes	☐ No
☐ Lungs ☐ Arms ☐ Legs		
Family history of clots	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Blood disorder	☐ Yes	☐ No

Contagious

AIDS or HIV positive	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
MRSA/VRE	☐ Yes	☐ No

Cardiovascular/Hematologic

Have you ever had a stress test?	☐ Yes	☐ No
Heart Catheterization?	☐ Yes	☐ No
Chest X-ray (date of last) _____________		
EKG (heart tracing) date of last ________		
Chest pains	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No
Heart palpitations	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No
Irregular heart beat	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No

Gastrointestinal

Colitis/irritable bowel	☐ Yes	☐ No
Motion sickness	☐ Yes	☐ No
Heart burn	☐ Yes	☐ No
Stomach problems	☐ Yes	☐ No
Constipation/diarrhea	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Gallbladder	☐ Yes	☐ No
Liver	☐ Yes	☐ No
Pancreatitis	☐ Yes	☐ No
Enlarged Spleen	☐ Yes	☐ No

Endocrine

Frequent drinking or urination	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Have you ever had high blood sugars?	☐ Yes	☐ No
Adrenal problems	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No
Hair/skin changes	☐ Yes	☐ No

Genitourinary

Kidney failure	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No
Burning on urination	☐ Yes	☐ No
Pregnancy	☐ Yes	☐ No
Menstrual problems	☐ Yes	☐ No

Skin & Breast

Skin cancer/abnormal moles	☐ Yes	☐ No
Open wound/rash	☐ Yes	☐ No
Skin condition	☐ Yes	☐ No
Breast biopsy	☐ Yes	☐ No
Do you have a problem with excessive scarring or keloid formation?	☐ Yes	☐ No

Psychiatric

Nervous breakdown	☐ Yes	☐ No
Psychiatric condition	☐ Yes	☐ No
Have you ever been under the care of a psychiatrist, psychologist or mental health counselor?	☐ Yes	☐ No

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PAST AND/OR SOCIAL HISTORY:
List any hospitalization and/or previous surgery, or existing medical conditions, including dates:
____

____

____

Are you allergic to or have you ever had a reaction to any medication or drug; local anesthetic; or general anesthetic?

Yes__________ No__________ If so: Type of reaction:____

Are you now or have you ever taken any medications or herbs regularly (aspirin, birth control pills, herbs, vitamins, etc., or prescription narcotics.

Currently taking:
____

____

Previously taken:
____

Are you now or have you ever taken a prescription or over-the-counter medication for allergies, stuffiness, difficulty breathing, sinus problems or other nasal problems? ☐ Yes ☐ No If so, please list:
____

Do you currently smoke? ☐ Yes ☐ No If yes, how many packs per day?_______ How many years?____________
E-Cigarettes/Vaping? ☐ Yes ☐ No Recreational or medical Marijuana? ☐ Yes ☐ No
Have you quit smoking? ☐ Yes ☐ No If yes, when?_______________________
Do you currently use nicotine gum or patches? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, how much?___________________ How often?__________________

Have you ever had a mammogram?☐ Yes ☐ No If yes, date of last mammo?___________ What clinic?_________________

Is your general health good? ☐ Yes ☐ No Any blood relative ever had breast cancer? _____________________________

FAMILY HISTORY:
Mother - age and health (if deceased, age at death and cause):____

Father – age and health (if deceased, age at death and cause):____

Siblings – sex, ages and health (if deceased, age at death and cause):_____________________________________

Children: ☐ Yes ☐ No If yes, ages:____

Your Occupation:____

Who will be your caregiver the day of surgery:____

____ _________________________________
Signature of Patient Date

____ _________________________________
Reviewed By Date

____ _________________________________
Signature of Physician Date