

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)

<p>General</p> <p>Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eyes</p> <p>Eye surgery <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dry eyes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glasses/contacts <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blindness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blurry/double vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ear/Nose/Throat</p> <p>Deafness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hoarseness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Breathing problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Musculoskeletal</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Neck/back problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stiffness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Atrophy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Neurological</p> <p>Neuromuscular disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Seizure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Multiple sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Visual/balance problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Allergies</p> <p>Latex allergy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Drug allergy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hematologic/Lymphatic</p> <p>Excessive bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Lymph node enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>History of blood clots <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;"><input type="checkbox"/> Lungs <input type="checkbox"/> Arms <input type="checkbox"/> Legs</p> <p>Family history of clots <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Contagious</p> <p>AIDS or HIV positive <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>MRSA/VRE <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Cardiovascular/Hematologic</p> <p>Have you ever had a stress test? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Catheterization? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chest X-ray (date of last) _____</p> <p>EKG (heart tracing) date of last _____</p> <p>Chest pains <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart palpitations <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Irregular heart beat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Gastrointestinal</p> <p>Colitis/irritable bowel <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Motion sickness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart burn <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Constipation/diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Gallbladder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Liver <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pancreatitis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Enlarged Spleen <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Endocrine</p> <p>Frequent drinking or urination <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever had high blood sugars? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Adrenal problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hair/skin changes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Genitourinary</p> <p>Kidney failure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney stones <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Burning on urination <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Menstrual problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Skin & Breast</p> <p>Skin cancer/abnormal moles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Open wound/rash <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Skin condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Breast biopsy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have a problem with excessive scarring or keloid formation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Psychiatric</p> <p>Nervous breakdown <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Psychiatric condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever been under the care of a psychiatrist, psychologist or mental health counselor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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MEDICAL HISTORY – PAGE 2

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 including malignant hyperthermia?

Yes _____ No _____ If so: Type of reaction: _____

Has any immediate family member ever had a reaction to anesthesia including malignant hyperthermia?

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