JOSEPH PLASTIC SURGERY

HEALTH HISTORY SURVEY

Name: _____ Date: _____

Height: _____ Weight: _____

Current Medications: _____

_____

_____

Medication allergies: _____

_____

Previous surgeries and approximate dates: _____

_____

_____

Do you smoke? If yes, how many packs per day? _____	Yes _____	No _____
Do you take aspirin?	Yes _____	No _____
Do you take any over-the counter drugs? If so, which drugs? _____	Yes _____	No _____
_____		
Have you taken Accutane?	Yes _____	No _____
Do you take diet pills?	Yes _____	No _____
Do you take any herbal medicines / supplements? If so, what? _____	Yes _____	No _____
_____		
Have you ever been diagnosed with rheumatoid arthritis, lupus, MS or any connective tissue disease?	Yes _____	No _____
Have you ever had shingles or cold sores?	Yes _____	No _____
Do you use alcohol? If yes, how much? _____	Yes _____	No _____
Have you ever had general or twilight anesthesia?	Yes _____	No _____
Do you or any family member have malignant hypertherma?	Yes _____	No _____
Have you had problems with nausea and vomiting after surgery?	Yes _____	No _____
Do you have problems with motion sickness?	Yes _____	No _____
Is there any history of breast cancer in your family?	Yes _____	No _____
Have you ever had breast cancer treatment?	Yes _____	No _____
If so what? _____		
Have you had a recent mammogram?	Yes _____	No _____
Have you ever had an abnormal chest x-ray?	Yes _____	No _____
Have you ever had a heart attack?	Yes _____	No _____
Have you ever had chest pain related to your heart?	Yes _____	No _____
Do you have a heart murmur or irregular beat?	Yes _____	No _____
Do you have Prolapse Mitral Valve?	Yes _____	No _____
Have you ever had high blood pressure?	Yes _____	No _____
Do you wake up at night short of breath?	Yes _____	No _____

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Have you ever had a stroke?	Yes___ No___
Have you ever had epilepsy, seizures, or fainting spells?	Yes___ No___
Do you have diabetes?	Yes___ No___
Have you ever had thyroid problems?	Yes___ No___
Do you have chronic bladder problems or kidney disease?	Yes___ No___
Have you passed bloody urine?	Yes___ No___
Do you have stomach, bowel, or gallbladder problems?	Yes___ No___
Have you ever had bloody bowel movements?	Yes___ No___
Have you ever been jaundiced?	Yes___ No___
Have you ever had hepatitis?	Yes___ No___
Do you have any bleeding tendencies?	Yes___ No___
Have you ever been anemic?	Yes___ No___
Have you ever had thrombophlebitis or do your ankles swell?	Yes___ No___
Do you have any arm or leg numbness or weakness?	Yes___ No___
Do you have any physical disabilities or orthopedic problems?	Yes___ No___
Have you ever received radiation therapy?	Yes___ No___
Do you have any history of hearing loss?	Yes___ No___
Have you ever had a broken nose?	Yes___ No___
Do you have chipped, loose, or capped teeth, dentures or braces?	Yes___ No___
Do you have frequent headaches or migraines?	Yes___ No___
Have you ever had eye problems or dry eye syndrome?	Yes___ No___
Is there any history of glaucoma in your family?	Yes___ No___
Do you wear contact lenses?	Yes___ No___
Do you have a chronic cough?	Yes___ No___
Do you have any breathing problems?	Yes___ No___
Have you had bronchitis, pleurisy, or pneumonia?	Yes___ No___
Have you had asthma?	Yes___ No___
Have you had a recent cold?	Yes___ No___
Do you have any lumps in your neck?	Yes___ No___
Do you have any sores in your mouth that do not heal?	Yes___ No___
Are you prone to fever blisters?	Yes___ No___
Do you have any hoarseness or trouble swallowing?	Yes___ No___
Do you have any reason to believe that you have been exposed to the AIDS virus?	Yes___ No___
Is there any reason to believe that you are pregnant?	Yes___ No___

Please list any other medical conditions not previously mentioned:_____

_____

_____

Patient Signature: _____ Date:_____

Parent/Guardian Signature:_____ Date:_____