

MEDICAL HISTORY

SKIN

	YES	NO
Have you had Skin Cancer	_____	_____
Chronic Skin Condition (hives, eczema, rashes)	_____	_____
Form Large Scars/Keloids	_____	_____
ACTH/ Steroid Materials (excluding skin creams/lotions)	_____	_____
Allergic to suture Materials(Catgut)	_____	_____
Frequent Infections/Boils	_____	_____
Cold Sores/Fever Blisters	_____	_____

NEUROLOGICAL

	YES	NO
Stroke	_____	_____
Fainting Spells	_____	_____
Convulsions	_____	_____
Seizures	_____	_____
Epilepsy	_____	_____

MENTAL

	YES	NO
Do you have, or have you had Significant Emotional Problems?	_____	_____
Any Recent Emotional Crisis?	_____	_____

LADIES

	YES	NO
Any Possibility You Are Pregnant?	_____	_____

BREAST SURGERY PATIENTS

	YES	NO
Have you had a mammogram? When? _____	_____	_____

MEDICATIONS

Please list all present medications including birth control pills, hormones, vitamins, herbal medications, diuretics, weight loss drugs. Include over the counter medications.

Are you allergic to any medications? YES _____ NO _____

List medication name and type of allergic reaction experience (i.e. Rash...etc.)

Are you allergic to Latex? YES _____ NO _____

Are you allergic to Tape? YES _____ NO _____

PAST SURGICAL HISTORY

Have you had previous surgery including cosmetic surgery? YES _____ NO _____ If yes, please list procedures.

Were there any complications? YES _____ NO _____ If yes, please list complications:

SOCIAL HISTORY

Do you exercise regularly? YES _____ NO _____ If yes, how much? _____
Have you ever smoked? YES _____ NO _____ If yes, do you still smoke? _____
At what age did you start? _____ At what age did you stop? _____ How many per day? _____
Do you consume alcoholic beverage? YES _____ NO _____ If yes, how much? _____
Do you use recreational drugs? YES _____ NO _____ If yes, please list type _____

FAMILY HISTORY

Is there any immediate family history of cancer, heart disease, diabetes, hypertension, abnormal bleeding or Genetic conditions? YES _____ NO _____ If yes, explain: _____

Have you or any family member had problems with anesthesia? YES _____ NO _____ If yes, explain:

I have completed all applicable questions. The above facts are true and correct to the best of my knowledge.

Patient Signature

Date