ANDOCHICK CENTER for COSMETIC SURGERY

HEALTH HISTORY

Patient Name: _____
Date: _____
Referring Doctor: _____
Pharmacy: _____

How did you learn of our office? (circle all that apply)

Word of mouth Internet Website Friends I'm A Previous Patient of Dr. A

BMI (office use)

To Our Patients:

Health problems that you may have or medication that you may be taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

*AGE: ____ HEIGHT: _____ WEIGHT:_____ OCCUPATION:_____

*REASON FOR YOUR VISIT TODAY?_____

*LIST YOUR SIGNIFICANT MEDICAL PROBLEMS:_____
(Both current and past)

_____

_____

_____

*LIST YOUR PREVIOUS OPERATIONS:_____
(And Approximate Dates)

_____

_____

*DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? (Including local anesthesia, Iodine, tape, etc.)
WHAT HAPPENS? _____

*LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING, AMOUNT AND HOW OFTEN:

_____ _____

_____ _____

_____ _____

	YES	NO
Have you been on steroids (Cortisone/Prednisone) in the last year?		
Do you currently smoke? If yes, how much per day?		
Do you drink alcohol? IF yes, Frequently___ Occasionally___ Rarely___ Amount___		

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	*Yes*	*No*	**HAVE YOU HAD OR DO YOU CURRENTLY HAVE...**	*Yes*	*No*
1. Rheumatic Fever?			19. Pulmonary Edema, Pulmonary Embolus, DVT (leg clots)?		
2. Damaged heart valves/mitral valve prolapse? Heart Murmur?			20. Convulsion, Epilepsy?		
3. Do you pre-medicate when you go to the dentist?			21. Stroke?		
4. High Blood Pressure?			22. Thyroid Trouble?		
5. Low Blood Pressure?			23. Diabetes?		
6. Chest Pain, Angina?			Are you on Dialysis?		
7. Heart Attack(s)?			25. Stomach Ulcers?		
8. Irregular Heart Beat?			26. Fever blisters of the lips?		
9. Cardiac Pacemaker?			27. AIDS or HIV infection?		
10. Asthma?			28. Problems of the Immune System?		
11. Tuberculosis? (if yes circle) **ACTIVE INACTIVE**			29. Mental Health Problems?		
12. Emphysema?			30. Dry Eye Symptoms?		
13. Shortness of Breath with walking?			31. Contact Lenses?		
14. Blood Disorder such as anemia?			32. Eye Disease/Glaucoma?		
15. Bleeding Tendency (Abnormal Bleed?) (excessive from a cut or tooth extraction)			33. Radiation Treatment or Chemotherapy?		
16. HEPATITIS: (if yes circle) **A B C**			34. Blood Transfusion?		
17. Jaundice, Hepatitis or Liver Disease?			35. Do you form large scars or keloids?		
18. Pain in your Calves with Walking?			36. Do you use a CPAP at night?		
19. Do you snore?			37. Do you have a family history of unexpected death(s) following general anesthesia or exercise; a family or personal history of MH, a muscle or neuromuscular disorder, high temperature following exercise; a personal history of muscle spasm, dark or chocolate colored urine, or unanticipated fever immediately following Anesthesia or serious exercise?		

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Date Signature of Patient

I have reviewed the information provided by the patient on this history and physical form. I further discussed with the patient any pertinent medical responses.

_____ _____

Date Signature of Physician