COSMETIC Surgical Center
The doctor to trust for your beautiful new look

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HEALTH QUESTIONS

NAME: _____AGE:_____HEIGHT:_____WEIGHT:_____

Reason for consultation: _____

PAST MEDICAL HISTORY

Medical: Do you or have you had:

_____Prolonged bleeding
_____Diabetes
_____High blood pressure
_____Heart trouble or disease
_____Fainting or black out spells
_____Shortness of breath/ chest pain
_____Ulcer
_____Heart murmur/ irregular pulse
_____Any other significant illness
_____If so, what _____

Surgical:

Previous Operations	Date	Problems with Surgery/Anesthesia
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: Are you allergic to or have reactions to medications, drugs, local anesthetics?

Medication	Type of Reaction When Medication Taken
_____	_____
_____	_____

Medications: Medications taken regularly (including **aspirin** and **birth control pills**):

Medication/Dosage/Frequency	Medication/Dosage/Frequency	Medication/Dosage/Frequency
1.) _____	3.)_____	5.) _____
2.) _____	4.)_____	6.) _____

Bleeding/Transfusions:

HAVE YOU TAKEN APSIRIN OR DRUGS CONTAINING ASPIRIN IN THE PAST TWO WEEKS?

_____Yes _____No

Do you or any members of your family have problems with prolonged bleeding after dental procedures or when cut?

_____Yes _____No

Have you had any blood transfusions?

_____Yes _____No If yes, any reactions? _____

Scarring: Have you had problems with excessive scarring?

_____Yes _____No

PERSONAL HISTORY

Occupation: _____
Do you smoke? _____Yes _____No If yes, number of packs per day: _____
Do you drink alcohol? _____Never _____Occasionally _____Regularly
Amount per day? _____
Do you take any drugs other than those listed previously? _____Yes _____No
If so, please list: _____

FAMILY HISTORY

Is there a history of any of the following in your immediate family? If so, list family member beside disease:

_____Diabetes_____
_____Hepatitis_____
_____High blood pressure_____
_____Stroke_____
_____Heart attack_____
_____Cancer (type) _____
_____Tuberculosis_____