BITNER
FACIAL PLASTIC SURGERY

Medical History Questionnaire

Name _____ DOB _____ Today's Date _____

Who is your primary care physician? _____ **Phone Number** _____

Have you had any other cosmetic, plastic or reconstructive surgery? Yes ◯ No ◯
If Yes, When, and what, if anything was done? _____
_____
Was it related to an injury? If so describe injury _____
Date of injury_____ Treatment received _____
Any complications? _____

Have you had any prior medical surgeries? ◯ Yes ◯ No
If Yes, When, what and where? _____
_____
Did you have a normal recovery? ◯ Yes ◯ No If no? _____

Have you had any problem with anesthesia? ◯ Yes ◯ No If yes? _____

PAST MEDICAL HISTORY
Please review the following list. If you have any of these conditions check ☑ Yes or No and the approximate year of diagnosis. If you have other conditions not listed for which you have taken medicine and/or seen a physician, please write them in the space provided.

Condition/Disease	Yes	No	Year	Condition/Disease	Yes	No	Year
Alcoholism/Cirrhosis	☐	☐		Crohn's Disease / colitis	☐	☐	
Anemia	☐	☐		Heart Disease	☐	☐	
Arthritis	☐	☐		Heart Attach (MI)	☐	☐	
Asthma/Emphysema	☐	☐		Hepatitis / Jaundice / Liver	☐	☐	
Bleeding/Blood Disorders/Clots	☐	☐		High Blood Pressure	☐	☐	
Bone or Spine	☐	☐		HIV positive / AIDS	☐	☐	
Cancer (past)	☐	☐		Lung Disease	☐	☐	
Leukemia	☐	☐		Prostate Disease	☐	☐	
Lymphoma	☐	☐		Seizures / Epilepsy	☐	☐	
Cataracts	☐	☐		Stroke(s)	☐	☐	
Diabetes (high blood sugar)	☐	☐		Thyroid Disease	☐	☐	
Gallbladder Disease/Stones	☐	☐		Ulcers / Stomach Pain	☐	☐	
Glaucoma	☐	☐		Other:	☐	☐	

Medications (List all medication names including non-prescription medications, vitamins, herbs, or supplement.)
Please include dosage, and how many you take daily (example: Lasix 20 mg 1 tablet daily)

1.	6.
2.	7.
3.	8.
4.	9.

Allergies (List all medications / health products with which you have had a bad reaction and what type of reaction occurred.)

_____

_____

_____

Hospitalizations/Surgeries (List all hospitalizations and surgeries with the approximate date)

Hospitalizations and/or surgeries	Date	Hospitalizations and/or surgeries	Date

○ Yes ○ No Do you have sinus problems or nasal allergies? Explain _____

_____

○ Yes ○ No Do you have skin rashes, irritations or infections? Explain _____

_____

○ Yes ○ No Have you ever had a fever blister, or "cold sores" or canker sores on your face, lips or in your mouth?

SOCIAL HISTORY

Do you currently smoke or chew tobacco? ○ Yes ○ No How many packs per day? _____

If no, have you in the past? ○ Yes ○ No How long ago did you quit? _____

Do you drink alcohol, beer or wine? ○ Yes ○ No How many drinks per week? ____ Per day? ___

If no, have you in the past? ○ Yes ○ No

Do you often get depressed? ○ Yes ○ No

If yes, are you currently being treated for depression? ○ Yes ○ No

The information you have provided is essential to a comprehensive evaluation.

Patient signature _____ Date _____

Physician signature _____ Date _____