



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 _____