Facial Plastic Surgery
Patient History Form

Name: ________________________________ **Ht.**______ **Wt.** ______ **Date:**____________

Chief complaint:____

Do you currently have or have you had these conditions, symptoms?

Y N Frequently tired	**Y N** Chronic cough	**Y N** Pacemaker
Y N High blood pressure	**Y N** Hoarseness	**Y N** Irregular/fast heart beat
Y N Stroke	**Y N** Sinus	**Y N** Heart murmur
Y N Migraine headaches	**Y N** Hay fever/allergies	**Y N** Heart attack
Y N Numbness/tingling arms/legs	**Y N** Shortness of breath	**Y N** Heart disease
Y N Convulsion/epilepsy/fits	**Y N** Bronchitis	**Y N** Psychiatric condition
Y N Fainting spells	**Y N** Asthma	**Y N** Swollen glands
Y N Glaucoma	**Y N** Pneumonia	**Y N** Unusual fever
Y N Other eye problems	**Y N** Emphysema	**Y N** Anemia
Y N Kidney/bladder problems	**Y N** Tuberculosis	**Y N** Bleeding tendencies
Y N Stomach or bowel problems	**Y N** Hiatal hernia	**Y N** Transfusion reaction
Y N Weight loss	**Y N** Chest pain	**Y N** Cancer
Y N Loss of appetite	**Y N** Pulmonary embolus	**Y N** Diabetes
Y N Latex allergy	**Y N** Fever Blisters/Canker Sores	**Y N** Genital Herpes
Y N Venereal Disease	**Y N** HIV/AIDS	**Y N** Thyroid Disease
Y N Hormonal Imbalance	**Y N** Hepatitis C	

Current Medications/ including vitamins, aspirin, herbs & minerals	**Dosage**	**How often**	**Allergies**

Y N If you needed a blood transfusion to save your life, would you accept one?
Y N Do you smoke? If yes, how much? _____ pkg/day, duration _____ years
If no, did you ever smoke? **Y N** When did you quit?
Y N Do you use smokeless tobacco?
Y N Do you live with a smoker?
Y N Do you drink alcoholic beverages? **Y N** Do you usually drink 2 or more a day?
Y N Do you drink more than 6 cups of coffee a day?

Y N Have you ever been hospitalized? If yes, for what condition?_______________________________
____

List previous surgeries including cosmetic procedures:	Type of anesthesia:	Date and place:

Family history:
Father: (circle) living deceased Cause: ___________________________________
Mother: (circle) living deceased Cause: ___________________________________
Siblings: (number) ____ living ____ deceased Cause: ___________________________________
Children:(number) ____ living ____ deceased Cause: ___________________________________

Is there family history of:
Y N Cancer Who? __________________ Cancer location? ___________________________
Y N Bleeding Who? __________________
Y N Have you or any member of your family had an unusual reaction to an anesthetic?
Please describe ____
Y N If patient is a child, are immunizations current?

Females: Last menstrual period? ________________________ Are you pregnant now? ________________

Occupation: ____

Current physician: _____________________________________ Address and telephone number (if known) ____
Date of last medical examination: ____________________, where? __________________________
Last known EKG: ______________________, where? ___________________________________
Last known chest x-ray: ________________, where? ___________________________________
Last known lab studies: ________________, where? ___________________________________
Last known eye exam: _________________, where? ___________________________________

Is there any other information we should be aware of concerning your health?
____

Do you have an advanced directive (a living will) in place regarding future medical care? **Y N**
Would you like the opportunity to complete an advanced directives form? **Y N**

To my knowledge, the above stated medical history is true and factual,

_________________________________ _________________________________
Patient /Guardian Date Nurse Signature Date

____
Reviewing Physician Date