

**PLASTIC SURGERY SPECIALISTS, P.C.**  
**CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE**

Kindly take a few moments to complete this form. We are working for your good health! Thank you.

1. Name \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date \_\_\_\_\_
2. Your Present Major Concern is: \_\_\_\_\_  
Your Secondary Concern is: \_\_\_\_\_
3. Reason why you would like to have this corrected \_\_\_\_\_  
\_\_\_\_\_
4. Do you have ANY specific fears about your contemplated procedure? YES NO  
If yes, explain \_\_\_\_\_  
\_\_\_\_\_
5. Have you talked with other doctors, including Plastic Surgeons, about this procedure? YES NO
6. Have you had ANY previous surgery (including Plastic Surgery)? YES NO  
If yes, please list with dates: \_\_\_\_\_  
Have you had an injury? \_\_\_\_\_ When? \_\_\_\_\_
7. Your general health:  Excellent  Good  Fair  Poor
8. Height: \_\_\_\_\_ Ft. \_\_\_\_\_ In. Your current weight: \_\_\_\_\_ lbs.  
Maximum Weight: \_\_\_\_\_ lbs. Date of maximum weight: \_\_\_\_\_  
Minimum Weight: \_\_\_\_\_ lbs. Date of minimum weight: \_\_\_\_\_
9. Medication you are presently taking, including dosage: \_\_\_\_\_  
\_\_\_\_\_
10. Do you take aspirin frequently? YES NO
11. Have you ever taken Phen-Fen or Redux? YES NO
12. Are you undergoing chemotherapy or radiation therapy? YES NO
13. Do you smoke? YES NO Amount \_\_\_\_\_
14. Do you drink alcohol? YES NO Amount \_\_\_\_\_
15. LIST GENERAL ALLERGIES (or write "none"): \_\_\_\_\_
16. LIST DRUG ALLERGIES (or write "none"): \_\_\_\_\_
17. Are you allergic to the adhesive on surgical tape? YES NO
18. Do you have any bleeding disorders? YES NO  
If yes, what type? \_\_\_\_\_
19. Do you bruise easily? YES NO
20. Have you ever had problems with anesthesia? YES NO  
If yes, explain \_\_\_\_\_
21. Have you been trying, or is there any chance you might be pregnant? YES NO
22. If you've recently had a baby, are you nursing? YES NO
23. Are you a keloid (heavy, elevated scar) former? YES NO
24. Are you under any excessive stress from your job or maladjustment of marriage? YES NO
25. Your psychiatrist's or psychologist's name & address \_\_\_\_\_  
\_\_\_\_\_
26. Do you have any long standing or recent emotional disorders? YES NO  
If yes, please explain \_\_\_\_\_

27. Have you or your BLOOD RELATIVES had:  Diabetes Your Relationship: \_\_\_\_\_  
 Cancer Your Relationship: \_\_\_\_\_  
 Bleeding Disorder Your Relationship: \_\_\_\_\_  
 Heart Disease Your Relationship: \_\_\_\_\_  
 Mental Illness Your Relationship: \_\_\_\_\_
28. List any serious illnesses you have had, or currently have that are under treatment \_\_\_\_\_

Have you ever had any of the following illnesses? Please circle yes or no and state the date							
			Date			Date	
AIDS/HIV+	YES	NO	_____	Kidney disease	YES	NO	_____
Anemia	YES	NO	_____	Lumps under skin	YES	NO	_____
Angina (heart pain)	YES	NO	_____	Mental Illness	YES	NO	_____
Arthritis	YES	NO	_____	Mitral Valve Prolapse	YES	NO	_____
Asthma	YES	NO	_____	Neck lumps	YES	NO	_____
Bladder disease	YES	NO	_____	Nervous breakdown	YES	NO	_____
Bleeding Disorder	YES	NO	_____	Numbness of skin	YES	NO	_____
Cancer	YES	NO	_____	Other eye disorders	YES	NO	_____
Cataract	YES	NO	_____	Pain in arms/legs	YES	NO	_____
Chest Pain	YES	NO	_____	Pancreatitis	YES	NO	_____
Chronic Fatigue Syndrome	YES	NO	_____	Phlebitis	YES	NO	_____
Colitis	YES	NO	_____	Reproductive System	YES	NO	_____
Depression	YES	NO	_____	Rheumatic Fever	YES	NO	_____
Diabetes	YES	NO	_____	Scarlet Fever	YES	NO	_____
Ear/Inner Ear Disease	YES	NO	_____	Seizures/similar disorders	YES	NO	_____
Eating Disorder	YES	NO	_____	Sinus disease	YES	NO	_____
Glaucoma	YES	NO	_____	Skin Cancer	YES	NO	_____
Gonorrhea	YES	NO	_____	Stomach Disorders	YES	NO	_____
Gout	YES	NO	_____	Stroke	YES	NO	_____
Heart Disease	YES	NO	_____	Syphilis	YES	NO	_____
Heart Murmur	YES	NO	_____	Thyroid Disease	YES	NO	_____
Hepatitis	YES	NO	_____	Trouble breathing	YES	NO	_____
High Blood Pressure	YES	NO	_____	Tumor:	YES	NO	_____
Intestinal Disorders	YES	NO	_____	Ulcer of Stomach	YES	NO	_____
Jaundice	YES	NO	_____	Ulcer of Duodenum	YES	NO	_____

**THESE SECTIONS SHOULD ONLY BE COMPLETED BY PATIENTS BEING SEEN FOR CONCERNS ABOUT HAIR REMOVAL, or THEIR BREASTS, NOSE, EYES, FACE, or VARICOSE/SPIDER VEINS**  
 PLEASE COMPLETE ONLY THE SECTION THAT APPLIES TO THE PURPOSE OF YOUR VISIT

**FOR HAIR REMOVAL PATIENTS**

Skin type:  Always burn & never tan     Always burn & sometimes tan     Sometimes burn & always tan  
 Never burn & always tan     Moderately pigmented (Hispanic, Asian)     Black

Going back three generations, is there an American Indian in your ancestry? \_\_\_\_\_ An African-American? \_\_\_\_\_

Location of hair to be removed: \_\_\_\_\_

Color of Hair: \_\_\_\_\_ Thickness of Hair: \_\_\_\_\_

How many years have you noticed this problem: \_\_\_\_\_ What age did it start? \_\_\_\_\_

Have you ever been treated for this problem? \_\_\_\_\_ If yes, by what method \_\_\_\_\_

Indicate any antibiotics or medications you are on that prohibit exposure to sun or light \_\_\_\_\_

When were you last exposed to the sun? \_\_\_\_\_ Tanning booth? \_\_\_\_\_ Artificial tan lotion? \_\_\_\_\_

Please do not pluck, wax or bleach hair you wish to be treated. It must be 1/16" - 1/8". Do not expose the area to sun.

Is there any additional information we should know? \_\_\_\_\_

**FOR SKIN CARE PATIENTS**

How would you like to improve your skin? \_\_\_\_\_

Do you use sun protection daily?    YES \_\_\_\_\_    NO \_\_\_\_\_

What skin care product line(s) do you currently use? \_\_\_\_\_

Would you be interested in a skin care consultation?    YES \_\_\_\_\_    NO \_\_\_\_\_

**FOR ANTI-AGING PATIENTS**

What are your major concerns with the way your body is aging? \_\_\_\_\_  
Are you currently taking vitamin/mineral dietary supplements? YES \_\_\_\_\_ NO \_\_\_\_\_  
What products are you currently taking? \_\_\_\_\_  
Are you now on Hormone Replacement Therapy? YES \_\_\_\_\_ NO \_\_\_\_\_  
Would you be interested in our natural Hormone Replacement Therapy program? YES \_\_\_\_\_ NO \_\_\_\_\_

**FOR RHINOPLASTY (NOSE) SURGERY PATIENTS**

Have you ever had nasal surgery or a nasal injury? \_\_\_\_\_ Date \_\_\_\_\_  
Do you have trouble smelling? \_\_\_\_\_  
Do you have frequent colds? \_\_\_\_\_  
Do you have trouble breathing? \_\_\_\_\_ Which side? \_\_\_\_\_  
Have you ever been told that you have a deviated nasal septum? \_\_\_\_\_  
Have you ever been told that you have nasal polyps? \_\_\_\_\_  
Have you ever had sinusitis? \_\_\_\_\_  
Have you ever had bleeding from the nose? \_\_\_\_\_

**FOR FACELIFT, EYELID SURGERY, OR LASER SKIN RESURFACING PATIENTS**

Do you have:  Dry Skin  Oily Skin  Average Skin  Acne (When? \_\_\_\_\_)  
Do you have uneven pigmentation/dark spots on your face? \_\_\_\_\_  
Have you ever had an injury or infection to your face? \_\_\_\_\_ Date \_\_\_\_\_  
Your Vision: Right Eye  Excellent  Good  Fair  Poor  
Left Eye  Excellent  Good  Fair  Poor  
Are your eyelids puffy or swollen upon awakening in the morning? Is one side more so? \_\_\_\_\_  
Have you had trouble with your eyes such as blurry or double vision, pain, drainage, spots, or blindness? \_\_\_\_\_  
Do you have "dry" eyes (itching of eyes)? \_\_\_\_\_  
Have you ever (even once) had a cold sore or fever blister? NEVER INFREQUENTLY FREQUENTLY  
Have you ever taken Accutane? \_\_\_\_\_ If so when did you stop? \_\_\_\_\_

**FOR VARICOSE/SPIDER VEIN PATIENTS**

When did you first notice your spider/varicose veins? \_\_\_\_\_  
Have your veins ever been treated? \_\_\_\_\_ If yes, what treatment? \_\_\_\_\_  
Date(s) of previous treatment \_\_\_\_\_ Where? \_\_\_\_\_  
Do your legs swell? \_\_\_\_\_ Are they ever painful? \_\_\_\_\_ Do they ever get cramps? \_\_\_\_\_  
Have you ever had blood clots in your legs (phlebitis)? \_\_\_\_\_  
If yes, please explain the treatment and dates \_\_\_\_\_  
Did your spider or varicose veins worsen after pregnancy? \_\_\_\_\_  
Do you consider your present vein condition to be:  Medical  Cosmetic  
Do your veins ever:  Ache  Swell  Itch  Become Red  Become tender  
Do any of your family members suffer from spider or varicose veins? Please list \_\_\_\_\_  
Indicate any antibiotics or medications you are on that prohibit exposure to sun or light \_\_\_\_\_  
Do you consider your complexion to be:  Dark  Medium  Light  
When were you last exposed to the sun? \_\_\_\_\_ Tanning booth? \_\_\_\_\_ Artificial tan lotion? \_\_\_\_\_  
Do you:  Always burn & never tan  Burn sometimes & tan sometimes  Always tan & never burn  
What are your expectations from vein therapy? \_\_\_\_\_

**FOR MAMMOPLASTY (BREAST) SURGERY PATIENTS**

What is your breast problem? \_\_\_\_\_  
Are both breasts the same size? \_\_\_\_\_  
Have you ever had discharge from either nipple? \_\_\_\_\_ Which side? \_\_\_\_\_  
Have you ever had bleeding from either nipple? \_\_\_\_\_ Which side? \_\_\_\_\_  
Are your breasts painful at the time of your period? \_\_\_\_\_  
Have you ever had a lump in your breast? \_\_\_\_\_ Which side? \_\_\_\_\_  
Did you have a breast biopsy? \_\_\_\_\_ Date(s) \_\_\_\_\_  
What is your bra size? \_\_\_\_\_  
Do you have:  Shoulder pain  Neck pain  Back pain

**THIS SECTION WILL BE COMPLETED DURING THE DOCTOR'S CONSULTATION WITH YOU**