

PERSONAL HEALTH HISTORY

Name: _____ Height: _____ Weight: _____

Reason for Visit: _____

Drug Allergies: _____

Are you Allergic to Latex? Y N Other Allergies (i.e. iodine, tape, skin sensitivity): _____

Present Medications: _____

Include: herbs, vitamins, over-the-counter meds, hormones and contraceptives.

Operations: (please give year) _____

Have you had any reaction to anesthesia? Y N Do you wear dentures? Y N

Please indicate which condition(s) you have by checking the box(es):

Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N (if so, what type_____)	<input type="checkbox"/> Y <input type="checkbox"/> N
Positive HIV test	<input type="checkbox"/> Y <input type="checkbox"/> N	Hemangiomas <input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma <input type="checkbox"/> Y <input type="checkbox"/> N
Keloid	<input type="checkbox"/> Y <input type="checkbox"/> N	Lupus <input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Port Wine Stain <input type="checkbox"/> Y <input type="checkbox"/> N
Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Problems <input type="checkbox"/> Y <input type="checkbox"/> N
Respiratory Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Abnormal Scarring <input type="checkbox"/> Y <input type="checkbox"/> N
Scleroderma	<input type="checkbox"/> Y <input type="checkbox"/> N	Hemophilia <input type="checkbox"/> Y <input type="checkbox"/> N
Hyperpigmentation	<input type="checkbox"/> Y <input type="checkbox"/> N	Shortness of Breath <input type="checkbox"/> Y <input type="checkbox"/> N
High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Bleeding Disorder <input type="checkbox"/> Y <input type="checkbox"/> N
Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Disease <input type="checkbox"/> Y <input type="checkbox"/> N

Have you ever been under the care of a psychiatrist/psychologist? _____

When was your last physical examination? _____ Who was the Physician? _____

Have you ever had a mammogram? _____ When? _____ Where? _____

Personal or Family History of Clotting Disorders? Y N

PLEASE BE EXTREMELY ACCURATE & CANDID WHEN ANSWERING THE QUESTIONS BELOW

THIS COULD HAVE AN EFFECT ON YOUR POSTOP CARE & RECOVERY

Do you smoke? Y N Have you ever smoke? Y N If yes, for how long? _____ When _____

Did you quit smoking? _____ Do you drink alcohol? Y N If yes, how much? _____

Do you take aspirin, Motrin, Nuprin, Ecotrin or Advil on a regular basis? Y N if so, how much? _____

Signature _____ Date _____