

Health History (Confidential)

For Office Use Only: Account #: _____

Patient Name: _____ Today's Date: _____

Birthdate: _____ Height _____ Weight _____ Reason for Today's Visit: _____

Interested in other plastic surgery procedures? _____

Please circle all conditions you have or have had:

- | | | |
|-----------------------|---------------------|----------------------|
| Alcoholism | Emphysema | Migraine |
| Anemia | Epilepsy | Multiple Sclerosis |
| Appendicitis | Eye Disease | Pacemaker |
| Arthritis/Joint Pain | Gallbladder Disease | Pneumonia |
| Asthma | Gout | Polio |
| Bleeding Disorders | Heart Disease | Psychiatric Care |
| Bronchitis | Hepatitis | Rheumatic Fever |
| Bowel Changes | Hernia | Scarlet Fever |
| Cancer | High Cholesterol | Sore that won't heal |
| Change in Mole | High Blood Pressure | Stroke |
| Chemical Dependency | HIV Positive | Thyroid Problems |
| Diabetes | Kidney Disease | Tuberculosis |
| Eating Disorder | Liver Disease | Ulcers |
| Other (Specify) _____ | | |

Women Only:		Date of Most Recent:
Breast Lump	Menstrual Problems	Mammogram _____
Breast Pain	Nipple Discharge	Pap Smear _____
Menopausal Symptoms	Vaginal Infections	Are you pregnant? _____

Men Only:	
Breast Lump	Lump in Testicle
Enlarged Breasts	Prostate Problems

Current Medications: _____

Allergies: _____

Hospitalizations/Serious Illness or Injury/Pregnancy

Year	Hospital	Condition	Outcome

Health Habits (how much)	Occupational Concerns
Alcohol: _____	Hazardous Substances: _____
Caffeine: _____	Heavy Lifting: _____
Drugs: _____	Stress: _____
Tobacco: _____	Your Occupation: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor responsible for errors or omissions that I may have made in the completion of this form.

Patient Signature Date