

# Health History (confidential)

For Office Use Only: Account #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ 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:

- |                     |                    |  |
|---------------------|--------------------|--|
| Breast Lump         | Menstrual Problems | <b>Date of Most Recent:</b><br>Mammogram _____ |
| Breast Pain         | Nipple Discharge   | Pap Smear _____                                |
| Menopausal Symptoms | Vaginal Infections | Are you pregnant? _____                        |

### Men Only:

- |                  |                   |               |
|------------------|-------------------|---------------|
| Breast Lump      | Lump in Testicle  | Sore on Penis |
| 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