

**PERSONAL HISTORY QUESTIONNAIRE**

**This information is confidential and will not be released without your authorization.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ PCP Name and Phone Number: \_\_\_\_\_

**PLASTIC SURGICAL PROCEDURES (Please include Age and Physician):**

- |                              |   |
|------------------------------|---|
| 1. Facelift _____            | 8. Breast reconstruction _____                      |
| 2. Forehead lift _____       | 9. Liposuction _____                                |
| 3. Eyelid lift _____         | 10. Tummy tuck _____                                |
| 4. Nasal surgery _____       | 11. Dermabrasion _____                              |
| 5. Breast augmentation _____ | 12. Chemical peel/laser resurfacing _____           |
| 6. Breast reduction _____    | 13. Botox _____                                     |
| 7. Breast lift _____         | 14. Facial Fillers (Juvederm, Restylane, etc) _____ |

**LIST ALL MEDICAL SURGERIES and/or ACCIDENTS (Include Year):**

**MEDICAL HISTORY: Do you have or have you had (If yes, give date of occurrence.)**

Aids/HIV	No	Yes _____	Dry Eyes	No	Yes _____	Hernia	No	Yes _____
Arthritis	No	Yes _____	Epilepsy / Seizures	No	Yes _____	<b>High Blood Pressure</b>	No	Yes _____
Asthma	No	Yes _____	Fibromyalgia	No	Yes _____	Kidney Disease	No	Yes _____
Autoimmune Disease	No	Yes _____	Gallbladder Disease	No	Yes _____	Pneumonia	No	Yes _____
Blood Clots	No	Yes _____	Glaucoma / Cataract	No	Yes _____	Psychiatric Disease	No	Yes _____
Cancer	No	Yes _____	Thyroid Disease	No	Yes _____	Sinus Problems	No	Yes _____
<b>Cold Sores (Herpes Simplex)</b>	No	Yes _____	Hay Fever / Allergies	No	Yes _____	Stroke	No	Yes _____
Depression	No	Yes _____	Headaches / Migraine	No	Yes _____	Tuberculosis	No	Yes _____
Diabetes	No	Yes _____	Heart Disease	No	Yes _____	Ulcers or Reflux	No	Yes _____
Dizziness /Vertigo	No	Yes _____	Hepatitis	No	Yes _____			

**List the name of all medications you are presently taking or have taken within the last month**

(Please include the name of the drug, dosage and frequency, all herbal supplements, Ibuprophen, Advil, Aspirin, and/or Motrin)

**ALLERGIES - List ALL drug and/or latex allergies**

Do you smoke? No Yes How much? \_\_\_\_ (Pack(s)/day) How Long: \_\_\_\_ (Years)  
 Do you drink alcohol? No Yes How much per week? \_\_\_\_\_  
 Do you drink coffee or caffeinated beverages? No Yes How many per day? \_\_\_\_ Do you wear glasses or contacts? No Yes  
 Have you had Lasik surgery in the last 6 mo? No Yes Describe: \_\_\_\_\_  
 Do you have problems with scarring? No Yes Describe: \_\_\_\_\_  
 Have your had any problems with anesthesia? No Yes Describe: \_\_\_\_\_

**FAMILY HISTORY: Have blood relatives had?**

High blood pressure	No	Yes	Arthritis	No	Yes	Asthma	No	Yes	
Diabetes	No	Yes	Stroke	No	Yes	Goiter / Thyroid	No	Yes	
Bleeding disorders	No	Yes	Breast cancer	No	Yes	Other cancer	No	Yes	Type: _____

**WOMEN ONLY**

Is there a chance you may be pregnant? No Yes Regular menses? No Yes Date of last menstrual period: \_\_\_\_\_  
 Any complications with pregnancies? No Yes Describe: \_\_\_\_\_  
 How many pregnancies? \_\_\_\_\_ How Many children? \_\_\_\_\_ Did you have a c-section? No Yes How Many? \_\_\_\_\_  
 Did you breast feed? No Yes How Many? \_\_\_\_\_  
 Date of Last Mammogram \_\_\_\_\_  Normal  Abnormal Specify abnormality \_\_\_\_\_  
 Breast Cancer: L R Date: \_\_\_\_\_ Breast Biopsy: L R Date: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

**The above information is accurate and complete to the best of my knowledge.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Reviewed with Patient:** \_\_\_\_\_