

The Aesthetic Surgery Center – New Patient History Form

What would you like to discuss at today's visit? _____

How did you hear about our practice? (Referral) _____

Contact Information

Cell Phone Number: _____

Home Phone Number: _____

Email Address: _____

Preferred method of contact: _____

Past Medical History:

Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hepatitis A/B/C	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Bleeding Disorders	<input type="checkbox"/> YES	<input type="checkbox"/> NO	High Cholesterol	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Blood Clots/DTV's	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Liver or Kidney Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Body Image Dysmorphia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Mental Illness/Psychiatric History	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Other Intestinal Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cold Sores	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Coronary Artery Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Stomach Ulcers/Other GI disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Eating Disorder	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Thyroid Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Emphysema	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Reactions to Anesthesia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Heart Attack	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Other	<input type="checkbox"/> YES	<input type="checkbox"/> NO
High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO			

Past Surgical Procedures: _____

Do you **smoke or chew tobacco**? YES NO

Cigars, cigarettes, pipe (circle all that apply)

How many packs per day _____

Does any person you work with or live with smoke? YES NO

Do you **drink alcohol**? YES NO

How much _____

Occupation: _____

Children/Ages: _____

If applicable, do you plan to become pregnant in the future? _____

Medications: _____

Allergies: _____

Are you **allergic to latex?** YES NO

Primary Physician: _____

If applicable: date of **last complete physical:** _____

If applicable: **date of last mammogram:** _____

Any other problems with your health?

If applicable: Wears Contacts	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Recent Weight Gain/Loss	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Skin Issues (rash, infection, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Dry Eyes	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hearing Loss	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Nose bleeds	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cold Sores	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Bleeding	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Chest Pain	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Shortness of Breath	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Abdominal Pain	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Diarrhea	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Urinary Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Headache	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Dizziness	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Joint Pain, Arthritis, Stiffness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Anxiety/Depression	<input type="checkbox"/> YES	<input type="checkbox"/> NO