Patient's Personal History

Date:_____

Patient Name:_____
Age:_____Date of Birth:_____Height:_____Weight:_____Sex: M/F
Date of Last Physical Examination:_____
(Your doctor's first/last name, clinic name):_____
Do you have any medication Allergies? Yes_____No_____
If yes, list the medication allergy and describe what happened to you:
_____
Do you have a Latex Allergy? Yes_____ No_____ Reaction:_____
Do you take medications and/or vitamin/supplements? Yes_____ No_____
If yes, what do you take?_____
_____
Have you ever had surgery or been hospitalized including cosmetic surgery?
Yes_____No_____
If yes, please list:_____
Do you or members of your household smoke? Yes_____No_____If yes, packs/day_____
Any history of sleep apnea or use of a CPAP? Yes_____No_____
Do you take aspirin or ibuprofen products? Yes_____No_____
Do you bruise easily? Yes_____No_____
Are you pregnant? (If applies) Yes_____No_____
Have you been treated for or exposed to AIDS? Yes_____No_____
Have you been treated for/exposed to Hepatitis?Yes_____No_____
Have you ever taken Acutane (a pill for acne)? Yes_____No_____Date finished_____
Have you ever had cold sores? Yes_____No_____
Have you ever had a low hemoglobin, low blood count or low iron? Yes_____No_____
Do you have a history of: (Check yes or no) **If yes, give date of occurrence**

- Blood clots Yes_____No_____ If yes, date_____
- High blood pressure Yes_____No_____ If yes, date_____
- Steroid use Yes_____No_____ If yes, date_____
- Heart murmur Yes_____No_____ If yes, date_____
- Heart Attack Yes_____No_____ If yes, date_____
- Other heart problems Yes_____No_____ If yes, date_____
- Diabetes Yes_____No_____ If yes, date_____
- Ulcers Yes_____No_____ If yes, date_____
- Treatment for psychological conditions or chemical dependency Yes_____No_____ If yes, date_____
- Any other health problems? Yes_____No_____
  If yes, please list:_____

Do you or any family members have a history of:

- Anesthetic complications Yes_____No_____
- **Blood Clots** or Bleeding complications Yes_____No_____

For Breast patients: Number of children_____ Any miscarriages/stillbirths? Y/N/ NA
Did you breast feed? **Y/N** # of kids_____ Do you have a family history of breast cancer? **Y/N**
If yes, who_____ Have you ever had any breast problems, biopsies or infections? **Y/N**
If yes, what and when?_____ What size of bra do you wear today?_____
Have you ever had a mammogram? **Y/N** If yes, when was your most recent one? _____Rev 1/11

Office use only:
Acc. By:
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Ref By:
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Measure:

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U:_____
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VH:_____
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Size:
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Ptosis:

L:_____
R:_____

Previous Scars:____
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Masto later if unhappy
Gel
Saline