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 shingles? Yes_____No_____

Have you ever had a low iron/hemoglobin 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/Heart Attack/other heart Yes_____No_____ If yes, date_____
- Diabetes Yes_____No_____ If yes, date_____
- Ulcers Yes_____No_____ If yes, date_____
- Treatment for psychological conditions Yes_____No_____ If yes, date_____
- Treatment for 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_____

Do you personally have unwanted fat? Yes_____No_____

Do you personally have unwanted hair? Yes_____No_____

Do you personally have thinning hair? Yes_____No_____

Do you have fine lines and wrinkles? Yes_____No_____

For Women patients: Number of children_____ Any miscarriages/stillbirths? **Y/N/ NA**

Are you done having children? **Yes/No/NA** 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**

Bra size today?_____

Have you ever had a mammogram? **Y/N** If yes, when was your most recent one? _____

Office use only:

Acc. By:

_____

_____

_____

Ref By:

_____

_____

_____

Measure:

CW:_____

U:_____

NAC:____

W:_____

SN:_____

VH:_____

N:N:_____

Size:

=

L>R

R>L

Ptosis:

L:_____

R:_____

Previous Scars:____

_____

AX

IM

IMDP

P

Masto later if unhappy

Gel

Saline