The Aesthetic Surgery Centre

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Patient Name:_____ Primary Language:_____

D.O.B._____Height:_____Weight:_____ Gender: Male / Female

What is the reason for your visit today? _____

Referring Physician (If any): _____

Have you ever seen another surgeon for the same problem or concern as todays visit? Yes No

Other Physicians you see (Example: Heart, Lung, and Endocrine Specialist):

_____ MD: TYPE:_____

_____ MD: TYPE:_____

_____ MD: TYPE:_____

Pre Surgical Medical Concern Questions:

Do you or any family member have a history of anesthesia problems? Yes No (If yes describe)_____

Do you or any family member have a history of malignant hyperthermia? Yes No

Are you currently on any blood thinning medications? Yes No TYPE:_____

Do you have any implantable devices? (i.e.: pacemaker) Yes No TYPE:_____

Do you have any problems with breathing? Yes No (If yes describe) _____

Do you have a history of any heart problems? Yes No (If yes describe) _____

Have you taken steroids in the last year? Yes No (If yes, dosage and timing)_____

Have you had your blood drawn in the last year? Yes No (If so, please provide us with a copy)

Have you had an EKG in the last year? Yes No (If so, please provide us with a copy)

Have you had a chest X-ray in the last year? Yes No (If so, please provide us with a copy of results)

Do you have an advanced directive or living will? Yes No (If so, please provide us with a copy)

Past Medical History (Please circle yes or no)

Neurological:

Migraine/Headache	Yes	No
Stroke/TIA/ Paralysis	Yes	No
Seizures	Yes	No

Other neurological issues:

_____

Pulmonary:

Asthma	Yes	No
Sleep Apnea	Yes	No
Emphysema/COPD	Yes	No
Pulmonary Embolism	Yes	No
Deep Vein Thrombosis	Yes	No

Other lung issues:

_____

Cardiac:

High Blood Pressure	Yes	No
Elevated Cholesterol	Yes	No
Angina/Chest Pain	Yes	No
Heart Attack	Yes	No
Pacemaker/Defibrillator	Yes	No
Irregular Heartbeat	Yes	No
Congestive Heart Failure	Yes	No
Heart Murmur	Yes	No
Valve Disease	Yes	No

Other heart issues:

_____

Vascular:

Peripheral Vascular Disease	Yes	No

Other vascular issues:

_____

Gastrointestinal:

Motion Sickness	Yes	No
Reflux/Heartburn	Yes	No
Crohns/Ulcerative colitis	Yes	No
Peptic Ulcers	Yes	No
Liver Disease /Cirrhosis/Jaundice	Yes	No

Other GI issues:

_____

Renal/Genitourary:

Kidney Disease/ Failure	Yes	No
Prostate Disease	Yes	No
Dialysis	Yes	No

Other Kidney issues:

_____

Endocrine:

Diabetes	Yes	No
(If yes) Insulin Dependent	Yes	No
Thyroid Disease	Yes	No

Other endocrine issues:

_____

Hematology/Infections Disease:

Anemia	Yes	No
Bleeding Tendencies	Yes	No
Leukemia/Lymphoma	Yes	No
HIV/AIDS	Yes	No

Other blood or infectious disease issues:

_____

Cancer and Malignancy:

Cancer/Malignancy	Yes	No

(If yes)

Location _____

Details _____

Chemotherapy	Yes	No
Radiation	Yes	No

Musculoskeletal:

Artificial Joint/Prosthesis	Yes	No
Multiple Sclerosis	Yes	No
Osteoporosis	Yes	No

Other:_____

Rheumatology:

Rheumatoid Arthritis	Yes	No
Osteoarthritis	Yes	No
Lupus/Scleroderma	Yes	No
Fibromyalgia	Yes	No

Other sarcoid or rheumatology issues:

_____

Skin:

Cancer	Yes	No
Psoriasis	Yes	No
Vitiligo	Yes	No

Psychiatric:

Depression/ Bi-Polar	Yes	No
ADHD	Yes	No
Dementia	Yes	No

Other Psychiatric issues: _____

Review of Systems (Please circle yes or no)

General:
Changes in weight Yes No
Progressive/Prolonged fatigue Yes No

Pulmonary:
Chronic Cough Yes No
Shortness of breath Yes No
Wheezing Yes No

Blood/Lymph:
Easy bruising Yes No
Frequent nose bleeds Yes No
Swollen glands Yes No

Head/Neck:
Decrease in hearing Yes No
New headaches Yes No
Dry mouth Yes No

Gastrointestinal:
Frequent Nausea/Vomiting Yes No
Abdominal pain Yes No
Frequent Diarrhea Yes No
Frequent Constipation

Neurological:
Dizziness Yes No
Difficulty walking Yes No
Sensory changes Yes No

Musculoskeletal:
Weakness/Numbness Yes No
Neck/Back pain Yes No
TMJ/Jaw pain Yes No

Eyes:
Redness Yes No
Watering Yes No
Light sensitivity Yes No
Dry feeling Yes No

Skin:
Changing moles Yes No
New Rash Yes No
Tendency to form keloid scars Yes No

Ability to Heal:
Does your skin appear fragile? Yes No
Do you sunburn easily? Yes No
Do you form a raised scar from a cut or burn? Yes No

Snoring Yes No

Cardiac:
Leg/Ankle swelling Yes No
Palpitations/Heart flutters Yes No
Do you have abnormal sensation with exertion? (Chest, arms, neck, back) Yes No

Psychiatric:
Memory loss Yes No
Feeling depressed/Anxious Yes No

Do you wax or use depilatories on your face? Yes No
Do you ever get cold sores? Yes No

Questions for Females only (Please circle yes or no)

Do you get regular periods? Yes No

Are you going through menopause? Yes No

Are you currently pregnant or trying to become pregnant? Yes No

Did you breast feed your children? Yes No

How many times have you been pregnant?

_____

How many children have you had?

_____

When was your last Mammogram? _____

What were the results? Normal/ Abnormal Details:_____

Please list all current medications (IF NONE, PLEASE WRITE NONE)

(PLEASE INCLUDE ANY VITAMINS, NUTRITIONAL OR HERBAL SUPPLIMENTS)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list Allergies (IF NONE, PLEASE WRITE NONE)

Patient Past Surgeries (If NONE, PLEASE WRITE NONE)

Surgery	Date	Complications (details)

Family History (Please circle yes or no)

Breast Cancer	Yes	No	(If yes) Details:_____
Other Cancer	Yes	No	(If yes) Details:_____
Heart Disease	Yes	No	(If yes) Details:_____

No contributing family history ☐

Social History

up to date

Occupation:_____

(Please check a box)

Married ☐ Single ☐

Divorce ☐ Widowed ☐

Physical Activity

How often do you exercise? (Please check a box)

Never ☐
Occasionally ☐
1-3 times weekly ☐
3-6 times weekly ☐

Level of Activity: (Please circle yes or no)

I Able to walk up 2 flights of stair Yes No
My health restricts my activity level Yes No

Recreational Drug use: (Please check a box)

No recreational drug use ☐

Current use of recreational drugs ☐

Type:_____

Previous history of recreational drug use ☐
Type:_____

Pediatrics Immunization History:

To the best of my knowledge my child is

On his/her immunizations:

☐Yes

No ☐

If no, Why?_____

Tobacco - Nicotine Use: (Please check a box)

Never Used ☐
Former Use ☐
Year started:_____Year Ended:_____

Current use ☐

1-5 x/day ☐
5-10 x/day ☐
10-20 x/day ☐
>20 x/day ☐

Alcohol: (Please check a box)

No alcohol use ☐

Alcohol use socially ☐
Amount per week:_____

Alcohol use daily ☐
Amount per day:_____

History of alcoholism ☐

Due to HIPAA Policies - Please list anyone you would allow access to your medical records

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Emergency Contact:

First: _____Last: _____

Relationship: _____

Contact Number: _____

ACKNOWLEDGEMENT:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of The Aesthetic Surgery Centre of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Patient Signature:_____ Date: _____

Doctor's Signature:_____ Date: _____

Reviewed and Updated

Patient Signature:_____ Date: _____

Please note changes: