Clinique Dallas
PLASTIC SURGERY
MEDSPA & LASER CENTER

HEALTH HISTORY

(All information is strictly confidential)

Name _____ **Age** _____ **Today's Date** _____/_____/_____
Reason For Visit _____
Height: _____' _____" **Weight:** _____ **lbs. What is the most you have ever weighed?:** _____ **lbs.**

PAST MEDICAL HISTORY

Please check if you have, or ever had any of the following conditions: ❑ **NONE**

Cardiovascular
- ❑ Anemia
- ❑ Angina / Chest pain
- ❑ Arrhythmia
- ❑ Congestive heart failure
- ❑ Heart attack
- ❑ Hearth murmur
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Heart valve disorder
- ❑ Pacemaker / Stent
- ❑ Rheumatic heart disease

Respiratory
- ❑ Asthma / Bronchitis
- ❑ COPD / Emphysema
- ❑ Pneumonia
- ❑ Tuberculosis

Gastro-intestinal
- ❑ Liver disease
- ❑ GERD
- ❑ Hernia
- ❑ Hepatitis
- ❑ Peptic ulcers

Blood
- ❑ Bleeding disorder
- ❑ Blood transfusion
- ❑ DVT / Blood clots / Pulmonary embolism

Neurologic
- ❑ Epilepsy
- ❑ Migraines
- ❑ Paralysis
- ❑ Stroke / TIA

Mental Health
- ❑ Alcohol / Drug dependency
- ❑ Anorexia /Bulimia
- ❑ Depression
- ❑ Psychiatric care
- ❑ Suicide attempt

Skin / Skeletal
- ❑ Jaundice
- ❑ Skin disorder
- ❑ Arthritis
- ❑ Gout
- ❑ Fracture

Immune / Infection
- ❑ AIDS / HIV
- ❑ Herpes / Fever blister
- ❑ Immune problem
- ❑ Venereal disease
- ❑ MRSA / VRE

Endocrine
- ❑ Diabetes
- ❑ Thyroid disorders

Other
- ❑ Glaucoma
- ❑ Kidney disorders

Do you have any type of cancer?:_____ **Impairments?**_____

Are you being treated for any other illness at this time? ❑ **Yes** ❑ **No. (If yes, please explain)**

_____

_____

Date of Last Physical: _____ **Results:** _____

Have you ever had SURGERY? ❑ **Yes** ❑ **No - If your answer is yes, please list:**

Have you, or a family member ever had a problem with anesthesia? ❑ **Yes** ❑ **No – If yes, please explain:**

Have you been diagnosed with a sleep disorder / sleep apnea? ❑ **Yes** ❑ **No**
Do you use a C-Pap Machine for your sleep disorder ❑ **Yes** ❑ **No**

Do you have DRUG ALLERGIES? ❑ **Yes** ❑ **No. If yes, please name of drug and reaction:**

FAMILY HISTORY (Only list blood related relatives.) ❑ **None**

❑ Diabetes		❑ Blood Clots		❑ High Blood Pressure	
❑ Stroke		❑ Heart Disease		❑ Cancer / Type	
❑ Other					

LIST ALL MEDICATIONS YOU ARE TAKING WITH NAME AND DOSAGE: ❑ **No Meds**

		❑ Weight control	❑ Estrogen / Hormones
		❑ Accutane (past year)	❑ Chemotherapy
		❑ Antibiotics	❑ Antidepressants
		❑ Aspirin / NSAID's	❑ Steroids
		❑ Blood thinners	❑ Vitamins / Supplements
		❑ Birth control	❑ Herbals / Homeopathic

Are you taking or have you ever taken recreational drugs? ❑Yes ❑No What type? _____
Please give more details:_____

Do you smoke? ❑Yes ❑No Quit? _____ How much? _____ # per day
Do you drink? ❑Yes ❑No ❑Socially ❑ Occasionally ❑ Moderately

WOMEN'S HEALTH ❑N/A

Pregnancies: _____ Live births: _____ Miscarriages: _____ Abortions: _____

Date of Last Menstrual Period: _____ Are you pregnant? ❑**Yes** ❑**No**

Date of Last Mammogram: _____ Results: _____

Current Bra Size: _____ Breast Cancer ❑**Yes** ❑**No** **History of Breast Biopsy**: ❑**Yes** ❑**No**

REVIEW OF SYSTEMS Please CIRCLE the following symptoms you have had recently. ❑No Symptoms

General:	Fatigue. Fever. Chills. Sweats. Sleep disturbance. Recent weight gain or loss.
Eyes, Ears, Nose, & Throat:	Blindness. Blurred vision. Cataracts. Contact lenses. Double vision. Dry eyes. Eye irritation. Eye pain. Excessive tearing. Red eyes. Sensitivity to light. Visual changes. Ear discharge. Difficulty breathing through nose. Dizziness. Hearing loss. Ringing in the ears. Chronic nasal congestion. Nose bleeds. Loss of sense of smell. Past nasal injury. Sinus problems. Ulcer/sore. Capped teeth. Loose teeth. Tooth pain. Dental problems. Dentures. Difficulty swallowing. Hoarseness. Snoring.
Cardiovascular:	Chest pain. Congestive heart failure. Irregular / rapid heartbeat. Heart attack. Low blood pressure. Mitral valve relapses / need for antibiotics for dental procedures. Foot swelling. Palpitations / Skipped beats. Poor circulation. Rheumatic fever. Varicose veins.
Respiratory:	Bronchitis. Bloody cough. Shortness of breath. Pneumonia. Recent cough. Wheezing. Tuberculosis.
Gastrointestinal:	Bloating. Blood in vomit / stools. Changes in appetite. Change in bowel habits. Chron's colitis. Constipation. Diarrhea. Hemorrhoids / rectal bleeds. Gastritis / reflux. Hepatitis / jaundice. Irritable bowel syndrome. Nausea / vomiting. Peptic ulcers. Ulcerative colitis.
Genitourinary:	Urinary infections. Urinating: Blood / Difficulty / Frequent / Pain / incontinent. STD. Yeast infections.
Musculoskeletal:	Arthritis. Difficulty walking. Extremity pain. Injuries. Joint pain. Leg cramps. Lupus Erythematosus, Rheumatoid arthritis. Unusual muscle weakness. Swelling.
Neurologic:	Dizziness / fainting. Numbness. Migraines / headaches. Seizures / epilepsy. Sensory loss. Stroke. Weakness / loss of balance.
Heme / Immunologic:	Bleeding gums. Blood clot / clotting disorder. Blood transfusion. Easy bruising. HIV complications. MRSA / VRE infections. Sickle Cell Anemia. Swollen lymph nodes.
Endocrine / Hormonal:	Adrenal disorders. Labile blood glucose levels. Neuropathy. Steroid use. Thyroid symptoms.
Skin Disease:	Acne. Burn injury. Difficulty healing wounds. Excessive or unsatisfactory scarring. Itching / Hives. Moles changing in appearance. Skin Cancer. Unexplained rash / inflammation.
Psychiatric:	Alcoholism. Anxiety. Depression. Drug abuse. Financial trouble. Marital problems. Schizophrenia.
Breasts:	Abnormal Mammogram. Bloody discharge. Benign lump / tumor. Cancer. Clear discharge. Milky discharge. Fibrocystic breasts. Pain. Reduction. Saline breast implants. Silicone breast implants.

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

X_____
Signature of Patient, Parent, Guardian or Personal Representative Date Time

_____
Name of Patient, Parent, Guardian or Personal Representative Date Time

_____
Reviewed by (Clinic Personnel, if applicable) Date Time

_____
Reviewed by (Pre-Op Personnel) Date Time