

Medical History Assessment

Name: _____ Date: _____

SOCIAL HISTORY:

Sex: M F

Married: Y N

Responsible Adult Available to Assist During Recovery Period: Y N

Relationship: _____

FAMILY HISTORY: Have any blood relatives ever had the following problems:

Abnormal Bleeding:	Y <input type="checkbox"/> N <input type="checkbox"/>	Coronary Surgery:	Y <input type="checkbox"/> N <input type="checkbox"/>	Kidney Disease	Y <input type="checkbox"/> N <input type="checkbox"/>
Abnormal Clotting:	Y <input type="checkbox"/> N <input type="checkbox"/>	Diabetes:	Y <input type="checkbox"/> N <input type="checkbox"/>	Tuberculosis:	Y <input type="checkbox"/> N <input type="checkbox"/>
Heart Attack:	Y <input type="checkbox"/> N <input type="checkbox"/>	Hypertension:	Y <input type="checkbox"/> N <input type="checkbox"/>	Other Illness:	Y <input type="checkbox"/> N <input type="checkbox"/>
Cancer:	Y <input type="checkbox"/> N <input type="checkbox"/>				

Have any of your family members or relatives had the following problems with anesthesia?

High Fever: Y N Death: Y N Other (please list): Y N

Please describe questions with a "Yes" answer:

PERSONAL HISTORY:

Have you ever received a transfusion? Y N If yes, what year? _____

Have you been tested for HIV? Y N If yes, what year _____

Test results: positive negative

Do you wear: Contact lenses: Y N Eye glasses: Y N Hearing aid: Y N
Dentures: Y N

Date last seen by Primary Care Physician: _____

Primary Care Physician (Name): _____
(Phone) (_____) _____ (Address) _____

WOMEN PATIENTS ONLY:

Number of pregnancies: _____ Number of children: _____

Last menstrual period: _____ Did you breast feed? Y N

If you are considering breast surgery, what is your current bra size? _____

Capital City Cosmetic Surgery

Medical History Assessment Continued

Patient Information: (PLEASE ADDRESS ALL QUESTIONS: Answers are important for your safety)

Have you had the following:	Yes	No	A. AGE _____ Height _____ Weight _____
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	B. PREVIOUS ANESTHETIC RECORD DATE LAST ANESTHESIA _____ Any Abnormal Reactions YES <input type="checkbox"/> NO <input type="checkbox"/> Relatives with Abnormal Reactions YES <input type="checkbox"/> NO <input type="checkbox"/>
If yes: CPAP or BIPAP Machine settings _____ Home Oxygen _____			
Epilepsy or seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	C. LIST PREVIOUS SURGERIES (TYPE AND DATE): _____ _____
Paralysis/Weakness/Muscular Dystrophy...	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	D. LIST MEDICATIONS YOU ARE PRESENTLY TAKING. <input type="checkbox"/> NONE 1. _____ 5. _____ 2. _____ 6. _____ 3. _____ 7. _____ 4. _____ 8. _____
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	
Lung Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any special concerns/needs regarding your visit in order for us to better take care of you? _____ _____ ASPIRIN? YES <input type="checkbox"/> NO <input type="checkbox"/> ANY OTHER ARTHRITIS MEDICATION? YES <input type="checkbox"/> NO <input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	LIST MEDICATIONS YOU ARE ALLERGIC TO AND WHAT HAPPENED WHEN YOU TOOK IT. <input type="checkbox"/> NONE _____ _____
Heart Problems..... Please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Immunizations Current	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to Latex (ie. rubber gloves)? YES <input type="checkbox"/> NO <input type="checkbox"/> Allergy to Avacodo, Banana, Kiwi, or Chestnuts? YES <input type="checkbox"/> NO <input type="checkbox"/>
Pacemaker/Implanted Defibrillator.....	<input type="checkbox"/>	<input type="checkbox"/>	
Peptic ulcer disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you: Smoke _____ pkg/day?..... YES <input type="checkbox"/> NO <input type="checkbox"/> Use alcoholic beverages?..... YES <input type="checkbox"/> NO <input type="checkbox"/> Frequently (Daily) Socially (A few times a month) Rare (A few times a year)
Frequent Heartburn/ Reflux	<input type="checkbox"/>	<input type="checkbox"/>	
Hiatal hernia.....	<input type="checkbox"/>	<input type="checkbox"/>	Wear contact lenses?..... YES <input type="checkbox"/> NO <input type="checkbox"/> Use recreational drugs?..... YES <input type="checkbox"/> NO <input type="checkbox"/> Type _____ Frequency _____
Jaundice/Hepatitis/ liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	
Blood disease/HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	Use herbal supplements/vitamins?..... YES <input type="checkbox"/> NO <input type="checkbox"/> Type _____ Frequency _____
Blood vessel disease (phlebitis).....	<input type="checkbox"/>	<input type="checkbox"/>	
Anticoagulant therapy (Blood Thinners)....	<input type="checkbox"/>	<input type="checkbox"/>	Patient Signature _____ Date _____ RN Signature _____ Date _____
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease: Hypo <input type="checkbox"/> Hyper <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dental caps/ bridges/ false or loose teeth.....	<input type="checkbox"/>	<input type="checkbox"/>	
Fracture of facial bones/ Neck or back.....	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	
Chest X-ray in past year.....	<input type="checkbox"/>	<input type="checkbox"/>	
Electrocardiogram in past year.....	<input type="checkbox"/>	<input type="checkbox"/>	
If female of childbearing age: Are you or could you be pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>	
Date of last period _____			
Have you been exposed to Tuberculosis in last 6 months?.....	<input type="checkbox"/>	<input type="checkbox"/>	
Personal/Family History of Malignant Hyperthermia.....	<input type="checkbox"/>	<input type="checkbox"/>	
Personal/Family History of Creutzfeldt-Jacob Disease?.....	<input type="checkbox"/>	<input type="checkbox"/>	
Other Medical Illnesses: _____ _____ _____			