



Center for Facial Cosmetic Surgery & MediSpa

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to us to do so.

PLEASE PRINT LEGIBLY AND FILL OUT ALL INFORMATION

Today's Date _____ / _____ / _____ Date of Last Physical Exam _____ / _____ / _____

Last Name: _____ First Name _____ Middle _____

Social Security No _____ Date of Birth _____ / _____ / _____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

HISTORY OF PRESENT ILLNESS

Please answer the following questions

Location of Problem _____

How long has the problem been present? _____

When did you first notice the problem? _____

Is the problem constant or variable? _____ Does this interfere w/your normal function? Y N

Does anything help or make the problem worse? _____

PAST MEDICAL & SOCIAL HISTORY

List all serious illnesses, _____
Surgeries, and when _____
They occurred _____

Are you on medications? Y N If yes, please list _____

Are you on a special diet? Y N If yes, please explain _____

Do you have allergies? Y N If yes, please list _____

Any Drug Allergies? Y N If yes, please list _____

Do you smoke? Y N Quit Do you drink? Y N Now much? _____

Any Comments on your Physical Health _____

REVIEW OF SYMPTOMS

Do you now or have you had any problems related to the following? Please explain any Yes answers.

Constitutional Symptoms

Fever Y N
Chills Y N
Headache Y N
Other _____

Eyes

Blurred Vision Y N
Double Vision Y N
Pain Y N
Other _____

Allergic/Immunologic

Hay Fever Y N
Drug Allergies Y N
Other _____

Neurological

Tremors Y N
Dizzy Spells Y N
Numbness/Tingling Y N
Other _____

Endocrine

Excessive Thirst Y N
Too hot/cold Y N
Tired/Sluggish Y N
Other _____

Gastrointestinal

Abdominal Pain Y N
Nausea/Vomiting Y N
Indigestion/Heartburn Y N
Other _____

Cardiovascular

Chest Pain Y N
Varicose veins Y N
High Blood Pressure Y N
Other _____

Integumentary

Skin Rash Y N
Boils Y N
Persistent Itch Y N
Other _____

Musculoskeletal

Joint Pain Y N
Neck Pain Y N
Back Pain Y N
Other _____

Ear/Nose/Throat/Mouth

Ear Infection Y N
Sore Throat Y N
Sinus Problems Y N
Other _____

Genitourinary

Urine Retention Y N
Painful Urination Y N
Urinary Frequency Y N
Other _____

Respiratory

Wheezing Y N
Frequent Cough Y N
Shortness of Breath Y N
Other _____

Hematologic/Lymphatic

Swollen Glands Y N
Blood Clotting Problem Y N
Other _____

Psychologic

Do you feel depressed? Y N
Have you considered suicide? Y N
Other _____