THE AESTHETIC SURGERY CENTRE

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David V. Pratt, M.D. Troy J. Woodman, M.D. Frederick W. Ehret, M.D. Todd M. Willcox, M.D.

Patient Name:____ Primary Language:_______________

D.O.B:_______ Stated Height: _________ Stated Weight:___________ Contact Person: _____________

Referring Physician: ____________________ Primary Care Physician: ______________________

Other Physicians you see (example: Heart, Lung, Endocrine specialist):

____M.D. type:__________________________________

____M.D. type:__________________________________

Reason for visit: ____

Have you ever seen another surgeon for the same problem or concern? □ Yes □ No

<u>Medical History:</u> (Please circle yes or no)

<u>Neurological:</u>

Migraine / Headache	Yes	No	Brain Aneurysm / Head Injury	Yes	No
Fainting	Yes	No	Macular Degeneration	Yes	No
Stroke / TIA / Paralysis	Yes	No	Retinal Detachment	Yes	No
Seizures	Yes	No	Blindness	Yes	No
Glaucoma	Yes	No	Other:_______________		

<u>Pulmonary:</u>

Asthma	Yes	No	Deep Vein Thrombosis	Yes	No
Aspiration	Yes	No	Pulmonary Embolism	Yes	No
Sleep Apnea	Yes	No	Pulmonary Hypertension	Yes	No
Pneumonia / Bronchitis	Yes	No	Lung Cancer / Tuberculosis (TB)	Yes	No
Emphysema / COPD	Yes	No	Other:_______________		

<u>Cardiac:</u>

High Blood Pressure	Yes	No	Congestive Heart Failure	Yes	No
Elevated Cholesterol	Yes	No	Heart Murmur / Valve Disease	Yes	No
Angina/Chest Pain	Yes	No	Pacemaker / Defibrillator	Yes	No
Heart Attack	Yes	No	Rheumatic Fever / Heart Infection	Yes	No
Irregular Heart Beat	Yes	No	Heart Surgery / Angioplasty	Yes	No
Atrial Fibrillation	Yes	No	Coronary Artery Disease	Yes	No
			Other:_______________		

<u>Gastrointestinal:</u>

Motion Sickness	Yes	No	Peptic Ulcers	Yes	No
Diarrhea	Yes	No	Liver Disease / Cirrhosis / Jaundice	Yes	No
Gallstones	Yes	No	Irritable Bowel Disease	Yes	No
Relux / Heartburn / Hiatal Hernia	Yes	No	Other:_______________		

Gynecology:

Condition			Condition		
Breast Cancer / Mastectomy	Yes	No	Uterine Cancer	Yes	No
Breast Disease	Yes	No	Prolapse	Yes	No
Endometriosis	Yes	No	Other:________________		

Age of first period _________ **Date of last period** _________ Age of menopause _________

Number of pregnancies __________ Number of births __________

Musculoskeletal:

Condition			Condition		
Artificial joint / prosthesis	Yes	No	Osteoporosis	Yes	No
Multiple Sclerosis	Yes	No	Other:________________		

Skin:

Condition			Condition		
Cancer	Yes	No	Eczema	Yes	No
Psoriasis	Yes	No	Other:________________		

Psychiatric:

Condition			Condition		
Depression / Anxiety	Yes	No	Schizophrenia	Yes	No
ADHD / Bi-Polar	Yes	No	Dementia	Yes	No
Eating Disorder	Yes	No	Other: ________________		

Endocrine:

Condition			Condition		
Diabetes	Yes	No	Thyroid Disease	Yes	No
(if yes, insulin dependent?)	Yes	No	Hypoglycemia	Yes	No
			Other: ________________		

Renal/Genitourinary:

Condition			Condition		
Kidney Stones	Yes	No	Prostate Disease	Yes	No
Kidney Disease	Yes	No	Frequent Urinary Tract Infections	Yes	No
Kidney Failure	Yes	No	Other :________________		

Vascular:

Condition			Condition		
Aneurysm	Yes	No	Vasculitis	Yes	No
Peripheral Vascular Disease/ poor circulation	Yes	No	Varicose Veins	Yes	No
			Other: ________________		

Rheumatology:

Condition			Condition		
Rheumatoid Arthritis	Yes	No	Raynaud's Disease	Yes	No
Osteoarthritis	Yes	No	Fibromyalgia	Yes	No
Lupus / Scleroderma	Yes	No	Other: ________________		

Hematology / Infectious Disease:

Condition			Condition		
Anemia	Yes	No	Sexually Transmitted Disease	Yes	No
Bleeding Tendencies	Yes	No	Hepatitis	Yes	No
Hemophilia	Yes	No	HIV / AIDS	Yes	No
Sickle Cell	Yes	No	Blood Transfusions	Yes	No
Leukemia / Lymphoma	Yes	No	Other: ________________		

Cancer/Malignancy: **Yes** **No**

Location: ______________________			Radiation	Yes	No
Chemotherapy	Yes	No	Date finished treatment: ____________		

Review of Systems: (Please circle yes or no)

General:

Changes in weight	Yes	No
Progressive/Prolonged Fatigue	Yes	No

Pulmonary:

Cough	Yes	No
Shortness of breath	Yes	No
Wheeze	Yes	No
Snoring	Yes	No

Cardiac:

Do you ever wake up short of breath	Yes	No
Leg / Ankle swelling	Yes	No
Do you sleep okay	Yes	No
Palpitations / Heart flutters	Yes	No
Abnormal sensation with exertion / (in the chest, arms, neck, back)	Yes	No

Infectious Disease:

Fever	Yes	No
Night Sweats	Yes	No
Recent Infection	Yes	No

Gynecologic/Urologic:

Incontinence	Yes	No
Difficulty / Painful urination	Yes	No
Blood in urine	Yes	No

Psychiatric:

Suicidal thoughts	Yes	No
Hallucinations	Yes	No
Memory loss	Yes	No
Feeling depressed/anxious	Yes	No

Blood/Lymph:

Easy bruising	Yes	No
Frequent nose bleeds	Yes	No
Swollen glands	Yes	No

Head and Neck:

Decrease in hearing	Yes	No
Ringing in the ears	Yes	No
New Headaches	Yes	No
Sinus Problems	Yes	No
Sore throat	Yes	No
Changes in voice	Yes	No
Dry mouth	Yes	No

Eyes:

Blurred vision	Yes	No
Eye pain	Yes	No
Redness	Yes	No
Watering	Yes	No
Light sensitive	Yes	No
Dry feeling	Yes	No

Gastrointestinal:

Frequent Nausea / Vomiting	Yes	No
Abdominal pain	Yes	No

Skin:

Changing moles	Yes	No
New rash	Yes	No
Tendency to form keloid scars	Yes	No

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

Past Surgical History: (please list name of procedure and date)

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

5. ______________________________ 6. ______________________________

Medications: (list all current medications and dosages)

1. ______________________________ 6. ______________________________

2. ______________________________ 7. ______________________________

3. ______________________________ 8. ______________________________

4. ______________________________ 9. ______________________________

5. ______________________________ 10. ______________________________

Drug Allergies: Yes / No **List:** ______________________________

Reactions:______________________________

Social History:

1. Occupation: ______________________

2. Married / Single / Divorced (circle one)

3. Have you ever used tobacco?: Yes No
If yes, # of packs per day?:_____ for # of years?:___
If you quit using tobacco, when?: ______________

4. Do you drink alcohol?: Yes No
How much?:__________ How often?: _________

5. Do you use recreational drugs?:Yes No
Type: ________________________

Family History: Please list any family medical history/problems.

	Age	Diseases	Cause of Death
Father	______	______________	______________
Mother	______	______________	______________

Pre-surgical / Anesthesia: Please circle yes or no

Do you use aspirin or NSAIDs (Motrin, Aleve, etc) containing medications? Yes No

Do you use Blood thinners (Coumadin/Warfarin, Heparin, Lovenox)? Yes No
Medication name:__________________________

Have you used diet pills in the last two weeks? Yes No
Medication name:__________________________

Have you taken steroids within the last year? Yes No
Medication name:________________ How long?:________

Have you ever taken accutane? Yes No
If yes, when was your last dose?:__________________

Have you or your immediate family had any reactions, problems or complications associated with anesthesia? Yes No
Describe: ______________________________

Do you or your family have malignant hyperthermia? Yes No
Describe: ______________________________

Do you exercise? Yes No
How often?: _______________How long?: _____________
Type:____
Is your level of activity related to health limitations?
Yes No
Describe: ____
Do you wear contact lenses? Yes No
Do you have caps, bridges, dentures or loose teeth?
Yes No
Describe: ____
Have you had blood drawn in the past month?
Yes No
If yes, which lab?:___________________________________

Have you had an EKG done in the last year?
Yes No
If yes, at what location?:______________________________
Have you had a chest x-ray done within the last year?
Yes No
If yes, at what location?:______________________________
Have you ever had a mammogram?
Yes No
If yes, date of last: ___________________________________
Have you had a recent medical evaluation by your Internist, Cardiologist, or Family Practitioner?
Yes No
If yes, Doctor's name:_______________________________
Do you have an advanced directive or living will?
Yes No
(If yes, please bring a copy with you on the day of surgery)

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:

Additional Information:
In order to give you the most complete experience today, please let us know if you would like information on any of the following (please circle yes or no):

Acne Treatment/Prevention	Yes	No	Anti-Aging Treatments/Products	Yes	No
Skin Cancer Prevention	Yes	No	Relaxing Massage	Yes	No
Body Treatments	Yes	No	Other:___________________________________		