

Aestique[®] Plastic Surgical Associates, Ltd.
MEDICAL HISTORY

NAME: _____ DATE: _____

HEIGHT: _____ / WEIGHT: _____ BLOOD PRESSURE: _____ AGE: _____

MARITAL STATUS: M ___ D ___ S ___ SEP ___ W ___ CHILDREN: YES ___ NO ___ HOW MANY? _____

PRIMARY REASON for visit: _____

REFERRING PHYSICIAN (Address & Phone) : _____

REFERRED BY (Address & Phone): _____

MEDICAL DOCTOR (Address & Phone): _____

PAST MEDICAL HISTORY:

Previous SURGERIES, date and reason: _____

Please list SERIOUS MEDICAL ILLNESS as a child or an adult (such as high blood pressure, heart problems, rheumatic fever, pneumonia, hepatitis, diabetes, thyroid disease or others). _____

Do you take any MEDICATIONS daily? _____ YES _____ NO

Please list medications, dosage and reason (INCLUDE ANY VITAMINS & HERBS): _____

Do you have any ALLERGIES, drug or other? YES NO

If yes, please list: _____

Do you have an ALLERGY to LATEX? YES NO

Do you have an allergy to CODEINE? YES NO

Have you ever been on ACCUTANE? YES NO

If yes, when: _____

Date of last MAMMOGRAM? _____

SOCIAL HISTORY:

What kind of work do you do? _____

Do you SMOKE? YES NO If yes, HOW MUCH? _____

Do you drink ALCOHOL? YES NO If yes, HOW OFTEN? _____

Do you ever use any NON-PRESCRIBED DRUGS? YES NO

If yes, WHAT? _____ HOW OFTEN? _____

FAMILY HISTORY:

Does anyone in your immediate family (mother, father, brothers, or sisters) suffer from high blood pressure, heart problems, diabetes, cancer or other? YES NO If yes, PLEASE LIST: _____

REVIEW OF SYMPTOMS:

Please circle any of the following which have frequently occurred within the last six months: (if none, circle none). HEADACHES, DIZZY SPELLS, FAINTING SPELLS, CHEST PAIN, NAUSEA, VOMITING, DIARRHEA, CONSTIPATION, DIFFICULTY SWALLOWING, COUGH UP BLOOD, SPIT UP BLOOD, BLOOD IN URINE, BLOOD IN YOUR STOOL, JAUNDICE, IRREGULAR MENSTRUAL PERIODS, BLEEDING AFTER MINOR CUT OR TOOTH EXTRACTION, TAKE ASPIRIN ONE A WEEK OR MORE OFTEN, BLURRY VISION, ANXIETY/DEPRESSION, FEVER, WEIGHT LOSS/GAIN, STIFF/PAINFUL JOINTS, NONE. If you should have any conditions or problems in the past which you feel we should know about, please comment:

PATIENT SIGNATURE: **X** _____

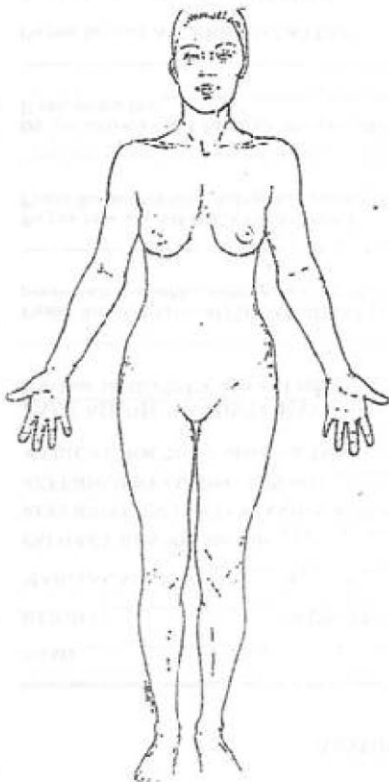
Do not write in this area. For office use only.

PATIENT NAME: _____

DATE: _____

NOTES: _____

Age:	_____
Sex:	_____
Height:	_____
WEIGHT	
Present:	_____
Highest:	_____
Lowest:	_____
Dress Size:	_____
Bra Size:	_____



IMPRESSION:

RECOMMENDATIONS:

