

**Aestique<sup>®</sup> 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: \_\_\_\_\_

**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: \_\_\_\_\_