Aestique® Plastic Surgical Associates, Ltd.
Medical History

Patient Name: _____ D.O.B: _____ Age: _____

Stated Height: _____ Stated Weight: _____ Blood Pressure: _____

Referring Physician (Address & Phone): _____

Primary Care Physician (Address & Phone): _____

How did you hear about us? _____

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

Past Medical History: (Please circle yes or no – ***must be within last 6 months***.)

Neurological:

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:	Yes	No

Pulmonary:

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:	Yes	No

Cardiac:

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:	Yes	No

Gastrointestinal:

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

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Medical History

Gyn/Breast:

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

Age of first period _____ Date of last period _____ Age of menopause_____
Number of pregnancies _____ Number of births _____ Breast Feeding _____
Last Mammogram _____ ☐ Reported as normal by patient ☐ Report interpreted as normal

Musculoskeletal:

Artificial join / prosthesis	Yes	No	Osteoporosis	Yes	No
Multiple Sclerosis	Yes	No	Other: _____	Yes	No

Skin:

Cancer	Yes	No	Eczema	Yes	No
Psoriasis	Yes	No	Other: _____	Yes	No
Do you go to a tanning bed?	Yes	No	Do you use sunblock?	Yes	No

How do you tan? [ ] Burn [ ] Usually Burn [ ] Sometimes Burn [ ] Rarely Burn [ ] Never Burn

Hair :

Hair thinning	Yes	No
Baldness	Yes	No
Hair Shedding	Yes	No

Psychiatric:

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

Endocrine:

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

Renal/Genitourinary:

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

Vascular:

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

Rheumatology:

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

Hematology / Infectious Disease:

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:	Yes	No

Cancer/ Malignancy:

Location: _____			Radiation	Yes	No
Chemotherapy	Yes	NO	Date finished treatment: _____		

Aestique® Plastic Surgical Associates, Ltd.
Medical History

Past Surgical History: **(**Please list name of procedure and date.)

1._____ 2._____

3._____ 4._____

5._____ 6._____

Medications: (Please list all current medications and dosages.)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Drug Allergies: YES / NO **List:**_____

Reactions:_____

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:

1. Occupation: _____

2. Single/ Married/Separated/Divorced/Separated (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	_____	_____	_____
Sibling	_____	_____	_____

Aestique® Plastic Surgical Associates, Ltd.
Medical History

Review of Systems: (*Please circle yes or no for **recurrent symptoms within the last 6 months**.*)

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 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
Felling 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
Develop cold sores	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

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 Aestique Plastic Surgical Associates 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:**_____

(REV 12/4/14)