

# History and Physical

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: M or F Married: Y or N Occupation: \_\_\_\_\_

Smoke: Y or N Amount: \_\_\_\_\_ Coffee/Tea/Cola: Y or N Amount: \_\_\_\_\_

Alcohol: Y or N Amount: \_\_\_\_\_ Daily Exercise: Y or N Amount: \_\_\_\_\_

**MEDICATIONS:** List dose or # of pills per day Non Prescription (Vitamins; Herbs)  
\_\_\_\_\_  
\_\_\_\_\_

Regular Aspirin Use: Y or N Dosage & frequency: \_\_\_\_\_

NSAID (Advil, Motrin, Ibuprofen): Y or N Dosage & frequency: \_\_\_\_\_

Cortizone Injections Past Year: Y or N Date(s) and Injection site: \_\_\_\_\_

**DRUG ALLERGY:** Y or N List drug(s) and type of reaction: \_\_\_\_\_

**LATEX ALLERGY** Y or N **TAPE ALLERGY** Y or N **HISTORY OF ACCUTANE THERAPY** Y or N

**FAMILY HISTORY:** Have any blood relatives ever had the following problems:

Abnormal Bleeding: Y or N	Asthma: Y or N	Kidney Disease: Y or N
Abnormal Clotting: Y or N	Diabetes: Y or N	Tuberculosis: Y or N
Anesthetic Problems: Y or N	Heart Attack: Y or N	Other Serious Illness: Y or N
Cancer: Y or N	Hypertention: Y or N	

Please describe questions with a "Yes" answer: \_\_\_\_\_

**PERSONAL PAST HISTORY:** Have you ever had:

Abnormal Bleeding: Y or N	Asthma: Y or N	Hypertension: Y or N	Psoriasis: Y or N
Abnormal Clotting: Y or N	Diabetes: Y or N	Sleep Apnea: Y or N	Eczema: Y or N
Acid Regurgitation: Y or N	Heart Attack: Y or N	Snoring: Y or N	Rosaeca: Y or N
Anemia: Y or N	Fainting Spell: Y or N	Weight Change: Y or N	Acne: Y or N
Angina: Y or N	Hepatitis: Y or N	History of Herpes: Y or N	Thyroid: Y or N

Please describe questions with a "Yes" answer: \_\_\_\_\_

Have you ever received a transfusion? Y or N if yes, what year? \_\_\_\_\_

Have you been tested for HIV? Y or N if yes, what year? \_\_\_\_\_ Test Results: Positive or Negative

Do you wear: Contact lenses: Y or N Eye glasses: Y or N Hearing Aid: Y or N Dentures: Y or N

**Surgical History:** Year and Type of Procedure – cosmetic and medically necessary

Indicate the type(s) of anesthesia received in the past, list any complications/reactions you experienced.

- Local anesthesia- (complications/reactions): \_\_\_\_\_
- General anesthesia- (complications/reactions): \_\_\_\_\_
- Spinal/Epidural- (complications/reactions): \_\_\_\_\_

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_