



Ditesheim

COSMETIC SURGERY

Beyond the Before & After

Medical History Information

At Ditesheim Cosmetic Surgery our goal is to make any planned surgical experience as safe as possible for you. Understanding your medical history, including any current or past medical problems is very important in developing a surgical plan that minimizes risk and complications. Please supply as much detail as needed and initial where indicated.

Name: _____ Date of Birth: _____ Age: _____

Reason for Consultation: _____

Primary Care Physician: _____ Address: _____

Gynecologist: _____ Address: _____

Are there any other doctors or persons to whom you would like us to communicate about your medical history or treatment?

If so, please list their names: _____

Do you have any current medical problems that require you to see a doctor on a regular basis? Yes ___ No ___

Please list the medical problems: _____

HEART DISEASE DATA	Have you ever had:	Do you have high blood pressure?	___ Yes ___ No
	___ Irregular Heart Beat	Do you take medicine for high blood pressure	___ Yes ___ No
	___ Chest Pain	If so, what medicine do you take?	_____
	___ Heart Attack	Do you take antibiotic prior to dental visits?	___ Yes ___ No
	___ CAD		
	___ High Cholesterol		

LUNG OR BREATHING DATA	Have you ever had:	Have you ever smoked cigarettes, cigars or pipe?	___ Yes ___ No
	___ Adult Asthma	Have you ever chewed tobacco or snuff?	___ Yes ___ No
	___ Emphysema	Do you currently use tobacco?	___ Yes ___ No If Yes, Amount? _____
	___ Bronchitis	If so, which word describes your smoking habit:	___ Past ___ Social ___ Current
	___ Sleep Apnea	Please initial here:	_____

GASTRO- INTESTINAL DATA	Do you have any of the following illnesses:	Have you ever had GI or stomach surgery?	Has your skin ever turned yellow?
	___ Colitis	___ Gallbladder	___ Yes ___ No
	___ Inflammatory Bowel	___ Appendix	
	___ Diarrhea	___ Gallbladder Disease	
	___ Constipation	___ Colon Cancer	
	___ Chronic Abdominal Pain ___ Reflux	___ Other _____	

BLEEDING PROBLEMS	Have you ever had:	Do you take any of these daily?	Have you ever had a blood clot?
	___ Easy Bruising	___ Persantine	___ Yes ___ No
	___ Blood Clots	___ Coumadin	Did the blood clot cause breathing problems?
	___ Sickle Cell Disease	___ Lovenox	___ Yes ___ No
	___ Anemia	___ Aspirin or Baby Aspirin	Dosage of Aspirin _____
	Do you have or have you ever had:		
	___ HIV ___ Jaundice ___ Hepatitis (A, B, or C)		

BRAIN DATA	Have you ever had:	Stroke	Have you ever experienced:
	___ Epilepsy	___ Brain Disease/Tumor	___ Numbness
	___ Multiple Sclerosis	___ Spinal Cord Damage/Disease	___ Weakness
	___ Nerve Damage/Disease	___ Neuromuscular Damage	___ Tingling (temporary or permanent)

EYE AND NOSE DATA

Do you wear: ___Glasses ___Contacts
Have you had Lasik surgery? ___Yes ___No
Do you have difficulty breathing? ___Yes ___No
Do you snore? ___Yes ___No

Do you use eye drops for: ___Dry Eyes ___Glaucoma ___Retinal Problems
If so, date of surgery: _____
Have you ever had nasal trauma? ___Yes ___No
Do you wear Dentures? ___Yes ___No

(OVER)

WEIGHT DATA

What is your current: _____ Height _____ Weight
Has there been any change in your weight over the last six months? ___Yes ___No
Do you need to diet to maintain your weight? ___Yes ___No
Do you take herbal or prescription medication for weight control? ___Yes ___No

SKIN DATA

Do you have a history of skin cancer? ___Yes ___No
Have you had previous skin surgery for melanoma? ___Yes ___No
Do you suffer from eczema, psoriasis or fever blisters? ___Yes ___No Which one _____
Do you have or have you had problems with the healing of skin incisions? ___Yes ___No
Do you have or have you had problems with keloid or hypertrophic scars? ___Yes ___No
Do you see a dermatologist? ___Yes ___No If yes, list doctor's name: _____

GENERAL DATA

Do you have: _____ Have you ever been told that you have diabetes? ___Yes ___No
___ Rheumatoid Arthritis Do you take insulin? ___Yes ___No
If Yes, what medication and dosage? _____
___ Lupus Do you have thyroid irregularity? ___Yes ___No
___ other autoimmune disease Have you had kidney problems, incontinence, swelling in your legs? ___Yes ___No
___ history of depression or post partum depression Do you take diuretics? ___Yes ___No

FEMALE DATA

Have you ever had: _____ Is there a history of breast cancer in your family? ___Yes ___No
If Yes, What relative? _____
___ Breast Pain What is your bra size? _____
___ Breast masses known or removed What was the date of your last mammogram? _____
___ Bleeding or discharge from nipple(s) Do you use birth control pills? ___Yes ___No
Do you use hormone replacement? ___Yes ___No
Are you or could you be pregnant? ___Yes ___No

SURGERY DATA

Have you ever had any surgeries? ___Orthopedic ___Oral ___GI ___Skin ___Gynecological
If yes, what was the surgery? _____
List date of surgery and doctor's name: _____
Have you ever had any cosmetic surgery? ___Breast Augmentation ___Liposuction ___Tummy Tuck ___Facial Surgery
If so, list date of surgery and doctor's name: _____
Have you ever had complications after surgery? ___Yes ___No. If yes, please explain: _____
Have you ever had any cosmetic injections? ___Botox ___Collagen ___Restylane ___Radiesse ___Juvederm

MEDICINE

What medicines do you take regularly? Please list the name and dosage: _____
What herbal supplements or vitamins do you take? _____
What medication have you taken for severe pain? _____
Do you have any food allergies? ___Yes ___No If yes, to what foods? _____
Do you have an allergy to any medication? ___Yes ___No If YES, what was the MEDICATION and REACTION? _____
Are you allergic to latex? ___Yes ___No Are you allergic to tape? ___Yes ___No

SOCIAL

At what frequency do you drink alcohol? ___Daily ___Weekly ___Socially ___None
Do you have children? ___Yes ___No
If yes, how many and what ages? _____
If you work outside the home, what type of work? ___Sedentary ___Light lifting ___Heavy lifting (more than 10 lbs.)

I have completed this form in its entirety and answered all the questions to the best of my knowledge:

Patient or legal guardian signature

Date