



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 ___ Inflammatory Bowel	___ Gallbladder	___ Yes ___ No
	___ Diarrhea ___ Gallbladder Disease	___ Appendix	
	___ Constipation ___ Colon Cancer	___ Gastric Bypass	
	___ Chronic Abdominal Pain	___ 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)



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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
 _____ Lupus If Yes, what medication and dosage? _____
 _____ other autoimmune disease Do you have thyroid irregularity? Yes No
 Have you had kidney problems, incontinence, swelling in your legs? Yes No
 Do you take diuretics? Yes No

FEMALE DATA

Have you ever had: _____ Is there a history of breast cancer in your family? Yes No
 _____ Breast Pain If Yes, What relative? _____
 _____ Breast masses known or removed What is your bra size? _____
 _____ Bleeding or discharge from nipple(s) What was the date of your last mammogram? _____
 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



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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? _____
 Have you ever had a bad reaction 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