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:
- ☐ Irregular Heart Beat
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ CAD
- ☐ High Cholesterol

Do you have high blood pressure? ☐ Yes ☐ No
Do you take medicine for high blood pressure ☐ Yes ☐ No
If so, what medicine do you take? _____
Do you take antibiotic prior to dental visits? ☐ Yes ☐ No

## LUNG OR BREATHING DATA

Have you ever had:
- ☐ Adult Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Sleep Apnea

Have you ever smoked cigarettes, cigars or pipe? ☐ Yes ☐ No
Have you ever chewed tobacco or snuff? ☐ Yes ☐ No
Do you currently use tobacco? ☐ Yes ☐ No If **Yes**, Amount? _____
If so, which word describes your smoking habit: ☐ Past ☐ Social ☐ Current
Please initial here: _____

## GASTRO-INTESTINAL DATA

Do you have any of the following illnesses:
- ☐ Colitis
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chronic Abdominal Pain
- ☐ Inflammatory Bowel
- ☐ Gallbladder Disease
- ☐ Colon Cancer
- ☐ Reflux

Have you ever had GI or stomach surgery?
- ☐ Gallbladder
- ☐ Appendix
- ☐ Gastric Bypass
- ☐ Other _____

Has your skin ever turned yellow? ☐ Yes ☐ No

## BLEEDING PROBLEMS

Have you ever had:
- ☐ Easy Bruising
- ☐ Blood Clots
- ☐ Sickle Cell Disease
- ☐ Anemia

Do you take any of these daily?
- ☐ Persantine
- ☐ Coumadin
- ☐ Lovenox
- ☐ Aspirin or Baby Aspirin

Have you ever had a blood clot? ☐ Yes ☐ No
Did the blood clot cause breathing problems? ☐ Yes ☐ No
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
- ☐ Epilepsy
- ☐ Brain Disease/Tumor
- ☐ Multiple Sclerosis
- ☐ Spinal Cord Damage/Disease
- ☐ Nerve Damage/Disease
- ☐ Neuromuscular Damage

Have you ever experienced:
- ☐ Numbness
- ☐ Weakness
- ☐ 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: _____ OVER
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:

☐ Rheumatoid Arthritis

☐ Lupus

☐ other autoimmune disease

☐ history of depression or post partum depression

Have you ever been told that you have diabetes? ☐ Yes ☐ No

Do you take insulin? ☐ Yes ☐ No

If Yes, what medication and dosage? _____

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:

☐ Breast Pain

☐ Breast masses known or removed

☐ Bleeding or discharge from nipple(s)

Is there a history of breast cancer in your family? ☐ Yes ☐ No

If Yes, What relative? _____

What is your bra size? _____

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

## 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.)

## MH Screening

Have you ever had: ☐ Muscle/Neuromuscular Disorder ☐ High Temperature Following Exercise ☐ Muscle Spasms

☐ Dark/Chocolate Colored Urine ☐ Unanticipated Fever Immediately Following Anesthesia Or Serious Exercise

☐ Family History Of MH ☐ Other: _____

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