PATIENT PERSONAL HISTORY

Name ____ Date__________

Date of Birth______________________________ Age__________________

Reason for office visit:____

List any medical conditions/illnesses: ________________________________

____

____

List previous surgeries & dates: ____________________________________

____

____

List previous cosmetic surgeries & dates: ____________________________

____

Have you been diagnosed with sleep apnea? ☐ Yes ☐ No

Please list any allergies: ____

Social History

Habits: ☐ Alcohol ☐ Tobacco ☐ Drugs ☐ Exercise ☐ Diet

Are you: ☐ Married ☐ Single ☐ Divorced Spouse's name: ________________

Children: YES/NO Ages: ____________________________________

Are you currently employed? __________ What is your occupation? ________________

Family History (check all that apply)

Diabetes ☐
Heart Disease ☐
Stroke ☐
High Blood Pressure ☐
Tuberculosis ☐
Epilepsy ☐
Kidney Disease ☐
Mental Illness ☐
Cancer ☐ What type? ________________ Who? ________________

Has anyone in your family ever had a problem with anesthesia? ☐ Yes ☐ No

What problem? ____

Mother: Living _______ Deceased ______ Age ______ Cause of Death ___________________________

Father: Living _______ Deceased ______ Age ______ Cause of Death ___________________________

ARE YOU CURRENTLY/RECENTLY EXPERIENCING: (check all that apply)

CONSTITUTIONAL
- Weight Loss ☐
- Fatigue ☐
- Fevers or night sweats ☐

EYES
- Glasses/Contacts ☐
- Double Vision ☐
- Glaucoma ☐
- Cataracts ☐

EAR, NOSE, THROAT
- Difficulty Hearing ☐
- Ringing in Ears ☐
- Vertigo ☐
- Sinus Infection ☐
- Hoarseness ☐

CARDIOVASCULAR
- Murmur ☐
- Chest Pain ☐
- Palpitations ☐
- Dizziness ☐
- Fainting Spells ☐
- Short of Breath ☐
- Difficulty Lying Flat ☐
- Swelling Ankles/Other ☐

HEMATOLOGIC
- Easy Bruising ☐
- Gums Bleed Easily ☐
- Prolonged Bleeding/ Clotting Disorder ☐

RESPIRATORY
- Cough ☐
- Coughing Blood ☐
- Wheezing ☐

GASTROINTESTINAL
- Heartburn ☐
- Nausea/Vomiting ☐
- Constipation ☐
- Change in BMs ☐
- Diarrhea ☐
- Difficulty Swallowing ☐
- Jaundice ☐
- Abdomen Pain ☐
- Blood in Stool ☐

GENITOURINARY
- Burning While Urinating ☐
- Frequent Urination ☐
- Blood in Urine ☐
- Abnormal Discharge ☐
- Difficulty Urinating ☐
- History Kidney Stone ☐
- History of Sexually Transmitted Disease ☐

FEMALES ONLY:
Are Periods Regular? Yes No
Age at Onset of:
Periods ____
Menopause ____

SKIN
- Rash/Sores ☐
- Lesions ☐
- Itching/Burning ☐

MUSCULOSKELETAL
- Joint Pain/Swelling ☐
- Stiffness ☐
- Muscle Pain ☐
- Back Pain ☐

NEUROLOGICAL
- Seizures ☐
- Weakness/Paralysis ☐
- Numbness ☐
- Tremors ☐
- Memory Loss ☐

ENDOCRINE
- Loss of Hair ☐
- Heat/Cold Intolerance ☐
- Change in Nails ☐

ALLERGIC/IMMUNOLOGIC
- Hay Fever/Asthma ☐
- Hives/Eczema ☐

PSYCHIATRIC
- Anxiety ☐
- Depression ☐
- Mood Swings ☐
- Difficulty Sleeping ☐