Aesthetic Enhancement
COSMETIC SURGERY & LASER CENTER

# Medical History

**Name** _____ Date _____

Age _____ Height _____ Weight _____ lbs

**Prior Surgeries**

Date | Type of Surgery

_____

_____

_____

**Hospitalizations**

Date | Reason for Hospitalization

_____

_____

**Have you had any of the following medical conditions in the past 5 years?** *(please check all that apply)*

| | | | | |
|---|---|---|---|---|
| ☐ Diabetes | ☐ Heart Trouble | ☐ Chest Pain | ☐ Rheumatic Fever | ☐ Nervous Breakdown |
| ☐ Angina | ☐ Stroke | ☐ Asthma | ☐ Hepatitis | ☐ High Blood Pressure |
| ☐ Liver Disease | ☐ Jaundice | ☐ Kidney Disease | ☐ Tuberculosis | ☐ Blood Transfusion |
| ☐ Epilepsy | ☐ AIDS/HIV | ☐ Emphysema | ☐ Black Stools | ☐ Blood in Urine |
| ☐ Psychiatric Care | ☐ Cancer *(list type)* _____ | | | |

**Medical History**

Are there any other medical conditions or medical history not listed above? (*Please explain*)

_____

_____

_____

Have you or a family member had a reaction to anesthesia? ☐ yes ☐ no

Have you or a family member had abnormal bleeding from surgery? ☐ yes ☐ no

**Medications**

Name of Medication | Dosage | Frequency

_____

_____

_____

Have you taken any of the following in the last 6 months?

☐ Steroids ☐ Aspirin/Advil ☐ Blood Thinners ☐ High Blood Pressure

**Allergies** _____

Have you ever had a problem or reaction with any of the following?

☐ Local Anesthetics ☐ Adhesive Tape ☐ Antibiotics ☐ Pain Killers ☐ Iodine ☐ Latex

**Tobacco History** ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chew # Years using _____ Packs/day _____

**Family Physician** _____ **Date of last checkup** _____

***For Women Only***

Date of your last period _____ Date of last mammogram _____

Are you pregnant? ☐ yes ☐ no # of Children _____ # births _____

Family history of breast cancer? ☐ yes ☐ no