



Inland Cosmetic Surgery
MEDICAL CORPORATION

Look your best. Feel your best.

Rancho Cucamonga, CA 91730 • (909) 987-0899 • (909) 987-9399 FAX

PATIENT HEALTH QUESTIONNAIRE

Your medical history is very important as it helps to alert us to any potential problems that might interfere with your surgery. Please take the time to fill this form out completely and accurately. The information will be kept confidential. If you need help, our staff can assist you.

DOB _____

Please print your NAME _____ Your AGE _____

How is your general HEALTH? _____ Are you under a DOCTOR'S care? _____

List all MEDICATIONS you are currently taking:

PRESCRIPTION _____

NON-PRESCRIPTION (aspirin, cold tablets, etc.) _____

List all drugs to which you are ALLERGIC: _____

OTHER allergies (bee sting, food, iodine, latex, tape, etc.): _____

Do you SMOKE? _____ If yes, how much (per day, week)? _____

Do you DRINK alcoholic beverages? _____ If yes, how much? _____

Have you used or do you now use recreational DRUGS? _____ If yes, list: _____

Any COSMETIC surgery you have had:

Major ILLNESSES and INJURIES you have had:

Any OPERATIONS you have had:

List any significant hereditary or infectious diseases in your family (i.e. diabetes, heart diseases, T.B., etc.):

Have you or any BLOOD RELATIVE of yours ever had a problem with ANESTHESIA or IV SEDATION?

(CONTINUED ON OTHER SIDE)

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS?

Eye or vision problems	(yes) (no)	Recurrent severe dizziness	(yes) (no)
Severe headaches	(yes) (no)	HIV positive	(yes) (no)
Asthma	(yes) (no)	Shortness of breath	(yes) (no)
Chest pain	(yes) (no)	Heart problems	(yes) (no)
High blood pressure	(yes) (no)	Rheumatic fever	(yes) (no)
Recurrent abdominal problems	(yes) (no)	Blood in bowel movements	(yes) (no)
Kidney or bladder problems	(yes) (no)	Blood in urine	(yes) (no)
Bleeding disorder, easy bruising	(yes) (no)	Seizures	(yes) (no)
Pregnancies	(yes) (no)	Menstrual disorder	(yes) (no)
Abnormal lump or node	(yes) (no)	Problems with bones or joints	(yes) (no)
Hepatitis	(yes) (no)	Tuberculosis	(yes) (no)
Venereal disease	(yes) (no)	Cancer	(yes) (no)
Diabetes	(yes) (no)	Chronic skin condition	(yes) (no)
Emotional problems	(yes) (no)	Psychiatric treatment	(yes) (no)
Problems with anesthesia	(yes) (no)	Complications after surgery	(yes) (no)
A bad surgical result	(yes) (no)	Unsatisfactory medical care	(yes) (no)

Other _____

IMPORTANT – Have you ever taken any type of diet medication?

Name of medication _____ When did you last take this medication? _____

THIS INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

_____ Patient Signature	_____ Date completed
_____ Reviewed by	_____ Date
_____ Reviewed by	_____ Date
_____ Reviewed by	_____ Date
_____ Reviewed by	_____ Date