Inland
COSMETIC
SURGERY

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Look your best. Feel your best.

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:

____

____

Any OPERATIONS you have had:

____

____

Major ILLNESSES and INJURIES 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?

Condition			Condition		
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