CHEGAR FACIAL PLASTIC SURGERY

MEDICAL HISTORY FORM

NAME: _____ **DOB:** _____
LAST **FIRST** **MI**

ALLERGIES TO MEDICATION & TYPE OF REACTION : _____

_____

ALLERGIES TO LATEX [ ] NO [ ] YES If yes, type of reaction: _____

CONTACT ALLERGIES [ ] NO [ ] YES If yes, allergen & reaction: _____

(examples: Tape, Adhesives, Betadine / Iodine, Isopropyl Alcohol, Vaseline, Aquaphor, or others)

CURRENT MEDICATIONS & DOSING: _____

_____

[ ] Check if separate list is attached for medications

DO YOU TAKE ASPIRIN, BABY ASPIRIN, OR BLOOD THINNERS REGULARLY? [ ] NO [ ] YES If yes, specify: _____

VITAMINS, MINERALS OR HERBAL SUPPLEMENTS: _____

(Including Vitamin E, Fish Oil, Green Tea extract, Ginseng, or others)

PAST SURGICAL PROCEDURES: _____

_____

PLEASE LIST ANY ACTIVE MEDICAL PROBLEMS: _____

_____

DO YOU OR HAVE YOU *EVER* HAD ANY OF THE FOLLOWING?

NO	YES		NO	YES	
[ ]	[ ]	HIGH BLOOD PRESSURE	[ ]	[ ]	BLEEDING DISORDERS
[ ]	[ ]	HEART DISEASE			Type _____
[ ]	[ ]	HEART ATTACK	[ ]	[ ]	HIV / AIDS
[ ]	[ ]	CHEST PAIN	[ ]	[ ]	HEPATITIS
[ ]	[ ]	HEART MURMUR	[ ]	[ ]	HEAVY BRUISING
[ ]	[ ]	STROKE	[ ]	[ ]	ANEMIA
[ ]	[ ]	SHORTNESS OF BREATH	[ ]	[ ]	KIDNEY DISEASE
[ ]	[ ]	ASTHMA	[ ]	[ ]	GLAUCOMA
[ ]	[ ]	COPD / LUNG DISEASE	[ ]	[ ]	DRY EYES/IRRITATION
[ ]	[ ]	MIGRAINE	[ ]	[ ]	VISUAL LOSS
[ ]	[ ]	EPILEPSY / SEIZURES	[ ]	[ ]	DROOPY EYELIDS
[ ]	[ ]	FACIAL PARALYSIS / NUMBNESS	[ ]	[ ]	DOUBLE VISION
[ ]	[ ]	CHRONIC SINUS INFECTIONS	[ ]	[ ]	AUTOIMMUNE DISORDER
[ ]	[ ]	NASAL ALLERGIES			Type _____
[ ]	[ ]	BROKEN NOSE	[ ]	[ ]	CANCER
[ ]	[ ]	FACIAL / JAW FRACTURE			Type _____
[ ]	[ ]	NASAL OBSTRUCTION	[ ]	[ ]	PROBLEMS W/ ANESTHESIA Reaction: _____
[ ]	[ ]	HEAVY NOSE BLEEDS	[ ]	[ ]	HARD TO NUMB/INSENSITIVE TO DENTAL ANESTHETICS (i.e. LIDOCAINE, NOVACAINE)

DO YOU HAVE A HISTORY OF KELOIDS/HEAVY SCARRING? [ ] NO [ ] YES If yes, explain: _____

DO YOU HAVE A HISTORY OF SENSITIVE SKIN/SKIN RASH? [ ] NO [ ] YES If yes, explain: _____

OTHER ILLNESSES: _____

DOES ANY FAMILY MEMBER HAVE A HISTORY OF ANY OF THE ABOVE? _____ If yes, explain: _____

_____

DO YOU OR HAVE YOU EVER SMOKED? [ ] NO [ ] YES _____ If yes, specify amount: _____

DO YOU DRINK ALCOHOL REGULARLY? [ ] NO [ ] YES _____ If yes, specify amount: _____

SIGNATURE: _____ **DATE:** _____