Medical History Questionnaire
(Confidential Information)

Patient's Name: _____ Date: _____

Reason for Visit: _____

Height: _____ Weight: _____

Do you smoke or use any nicotine replacement product? _____ If so, how much per day? _____

Medical History: Please check the following

High Blood Pressure……yes____no____

Bleeding Disorder…….yes____no____

Anemia…….yes____no____

Liver Disease…….yes____no____

Heart Disease……yes____no____

Psychiatric Illness……yes____no____

HIV…….yes____no____

Skin Disease……..yes____no_____

Thyroid Disease……..yes____no_____

Lung Disease…….yes____no_____

Tuberculosis……..yes____no_____

Shortness of Breath..yes____no_____

Hepatitis……yes____no_____

Diabetes……yes____no_____

Please list any other medical history the doctor should be aware of:

_____

Please list all previous surgeries, as well as cosmetic:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Please list any complications or problems you experienced during or following the above procedures:

_____

Family History:

Father: _____ Mother: _____

Siblings: _____ Children: _____

Laughlin Plastic Surgery

Medical History Questionnaire (cont'd)

(Confidential Information)

MEDICATIONS: Please list medications you currently take, including appetite suppressants, vitamins, etc.

_____

_____

Do you take any Aspirin or any Aspirin-containing compound? _____If yes, explain below:

_____

_____

Do you have any **ALLERGIES and/or SENSITIVITIES** to the following medications:

Penicillin……..yes_____no_____

Sulfa……yes_____no_____

Codeine……yes_____no_____

Latex……..yes_____no_____

Aspirin……..yes_____no_____

Xylocaine…….yes_____no_____

Adhesive tape……..yes_____no_____

Tetanus Toxix……yes_____no_____

Other Antibiotics (list)……yes_____no_____

_____

Any other allergies not listed above: _____

_____

Do you wear eyeglasses or contacts? _____

Primary Physician: _____ Date of last check-up? _____

Phone #: _____