Health History Form

NORTH TEXAS
FACIAL PLASTIC SURGERY

Reason for visit today?____

Past/Current Hx (Check all applicable)

__Lung Disease __High Blood Pressure __Asthma __Bleeding Disorder
__Liver Disease __Mitral Valve Prolapse __Keloids __HIV/Hepatitis
__Kidney Disease __Heart Disease __Chest Pain __MRSA
__Fever Blisters __Dry Eyes __Diabetes __Seizures
__Sleep Apnea __Congestive Heart Failure __Heart Attack __Nosebleeds
__Cancer __Vision Problems:__________________
Type/Treatment_____________________________________
Other Major Illnesses:____
Have you or anyone in your family had complications from anesthesia? If Yes, please explain:
____
Do you have Excessive Bleeding or Bruising? YES/NO
Do you drink alcohol? YES/NO If Yes, Type/How often? __________________________________
Do you or have you used Tobacco products? If Yes, Type/How often?__________________________
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Medications:

Name	Reason for Taking	Frequency/Dose

List all drug allergies and reactions:____

Pharmacy Name and Number ____

List all physicians you currently see and their specialty:

Physician Name	Specialty	Phone Number

List all cosmetic and non-cosmetic surgeries and dates:

Name___________________________________ DOB__________________ Date_______________________