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?_____

****

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_____