Aesthetic
Center for Facial Cosmetic Surgery & MediSpa

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to us to do so.

PLEASE PRINT LEGIBLY AND FILL OUT ALL INFORMATION

Today's Date_____/_____/_____ Date of Last Physical Exam _____/_____/_____
Last Name:_____First Name_____Middle_____
Social Security No_____ Date of Birth_____/_____/_____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

_____
_____
_____

HISTORY OF PRESENT ILLNESS

Please answer the following questions

Location of Problem_____
How long has the problem been present?_____
When did you first notice the problem?_____
Is the problem constant or variable?_____Does this interfere w/your normal function?◯Y ◯N
Does anything help or make the problem worse?_____

PAST MEDICAL & SOCIAL HISTORY

List all serious illnesses, Surgeries, and when They occurred

_____ _____
_____ _____
_____ _____
_____ _____

Are you on medications? ◯Y ◯N If yes, please list_____
_____
_____

Are you on a special diet? ◯ Y ◯N If yes, please explain_____
_____

Do you have allergies? ◯Y ◯N If yes, please list_____
_____

Any Drug Allergies? ◯Y ◯N If yes, please list_____
_____

Do you smoke?◯Y ◯N Quit Do you drink? ◯Y ◯N Now much?_____

Any Comments on your Physical Health_____
_____

REVIEW OF SYMPTOMS

Do you now or have you had any problems related to the following? Please explain any Yes answers.

Constitutional Symptoms
Fever ○Y ○N
Chills ○Y ○N
Headache ○Y ○N
Other_____

Integumentary
Skin Rash ○Y ○N
Boils ○Y ○N
Persistent Itch ○Y ○N
Other_____

Eyes
Blurred Vision ○Y ○N
Double Vision ○Y ○N
Pain ○Y ○N
Other_____

Musculoskeletal
Joint Pain ○Y ○N
Neck Pain ○Y ○N
Back Pain ○Y ○N
Other_____

Allergic/Immunologic
Hay Fever ○Y ○N
Drug Allergies ○Y ○N
Other_____

Ear/Nose/Throat/Mouth
Ear Infection ○Y ○N
Sore Throat ○Y ○N
Sinus Problems ○Y ○N
Other_____

Neurological
Tremors ○Y ○N
Dizzy Spells ○Y ○N
Numbness/Tingling ○Y ○N
Other_____

Genitourinary
Urine Retention ○Y ○N
Painful Urination ○Y ○N
Urinary Frequency ○Y ○N
Other_____

Endocrine
Excessive Thirst ○Y ○N
Too hot/cold ○Y ○N
Tired/Sluggish ○Y ○N
Other_____

Respiratory
Wheezing ○Y ○N
Frequent Cough ○Y ○N
Shortness of Breath ○Y ○N
Other_____

Gastrointestinal
Abdominal Pain ○Y ○N
Nausea/Vomiting ○Y ○N
Indigestion/Heartburn ○Y ○N
Other_____

Hematologic/Lymphatic
Swollen Glands ○Y ○N
Blood Clotting Problem ○Y ○N
Other_____

Cardiovascular
Chest Pain ○Y ○N
Varicose veins ○Y ○N
High Blood Pressure ○Y ○N
Other_____

Psychologic
Do you feel depressed? ○Y ○N
Have you considered suicide? ○Y ○N
Other_____