North Coast Plastic Surgery Health History Form

Legal Name _____

Sex _____ Age _____ DOB _____ Height _____ Weight _____

Home Phone _____ Cell Phone _____

Email : _____

Please specify if you would like text and email appointment reminders : Text □ Email □

Do you have any specific privacy requests regarding phone calls, texts, or emails?

_____

Address : _____ State _____ Zip Code _____

How did you hear about us? _____

Employer _____Occupation _____

Yes	No	Do you have any Cardiac History? Please circle all that apply (Heart Attack / Angina / Chest Pain Stroke / Heart Disease / Stents / Mitral Valve Prolapse / Irregular Heartbeat/ Pacemaker / Fainting If you circled yes, please provide more information. Are you under the care of a cardiologist Y / N If yes when was the last time you were seen by your cardiologist? What is the name of your cardiologist?
Yes	No	Do you have high blood pressure/hypertension or do your currently take any medication to lower your blood pressure ? Do you take your medication regularly as prescribed by your doctor Y / N Do you monitor your blood pressure at home on a regular basis Y / N
Yes	No	Are you diabetic or pre- diabetic or have a history of gestational diabetes or hypoglycemia Do you monitor your blood sugar at home on a regular basis Y / N Are you regularly seeing a Medical Doctor to manage your diabetes Y / N When were you last seen by this Doctor?
Yes	No	Do you have issues with your Kidneys / Bladder / Prostate / Liver If yes please explain issues.
Yes	No	Previous Surgeries? Please list with approximate year and type of anesthesia if known.
Yes	No	Have you or anyone in your family had a reaction to anesthesia? (nausea / vomiting, high fever, seizure, malignant hyperthermia)

Yes	No	Circle any of the following that apply:	Yes	No	Circle any of the following that apply
		Asthma, do you use an Inhaler? Y / N Coughing / Tuberculosis / Breathing issues			Anemia / Thalassemia / Sickle Cell / Clotting problems / Blood Thinner Usage
		Sleep Apnea CPAP? Yes / No			Difficulty Opening Mouth / Difficulty Moving Your neck
		Seizures (epilepsy) Date of last incident:			Drug use / Dependency: *It is important for your safety to inform the anesthesiologist*
		Headaches / Neurological / Anxiety / Depression			Do you drink Alcohol? How Much? Do you smoke Y / N PPD Do you use any nicotine products?
		Heartburn / Reflux / Ulcers / Hiatal			History of : MRSA / Poor wound healing / HIV / Hepatitis / C-Diff
		Thyroid Y / N Hyper / Hypo			Are you currently taking antibiotics? Why?

Allergies	Reaction	Allergies	Reaction

Current Medication History
Include over the counter medications

Vitamins and Herbal supplements	**Dose & Frequency**	**Reason for taking**

Patient's / Legal Guardian's Signature _____ Date _____