

# Hamilton Facial Plastic Surgery

## Medical History

Patient Name (Last, First, MI) \_\_\_\_\_

Age \_\_\_\_\_

Today's Date \_\_\_\_\_

### Medical History

What surgery are you considering? \_\_\_\_\_

Have you consulted another physician in regards to this type of surgical procedure? **Y N** If yes, who? \_\_\_\_\_

Have you discussed this surgery with your family? **Y N** Are they agreeable? **Y N** \_\_\_\_\_

Have you had any previous cosmetic surgery? **Y N** \_\_\_\_\_

When and what surgical procedure? \_\_\_\_\_

Who performed the surgery? \_\_\_\_\_ Where was it performed? \_\_\_\_\_

Were you satisfied with the results? **Y N** If not, why? \_\_\_\_\_

Would you like to receive additional information on cosmetic dental options? **Y N** \_\_\_\_\_

**Yes No** Are you allergic to any medications? \_\_\_\_\_

**Yes No** Have you ever received local anesthesia? Novacaine or Xylocaine (please circle) \_\_\_\_\_

**Yes No** Did you have any "reaction" to the anesthesia? Explain: \_\_\_\_\_

**Yes No** Are you taking ANY medications (including birth control or aspirin)? vitamins or supplements?  
Please list and how often: \_\_\_\_\_

**Yes No** Are you currently pregnant? \_\_\_\_\_

**Yes No** Have you ever been treated with Accutane? \_\_\_\_\_

**Yes No** Have you ever had any injury or surgery to or around the face, nose, neck, eyes? When? \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Explain? \_\_\_\_\_

Has any of your family members been affected by any of the following conditions?

If so please identify who and their relationship to you.

**Yes No** Heart Trouble \_\_\_\_\_ **Yes No** Excessive Bleeding \_\_\_\_\_

**Yes No** High Blood Pressure \_\_\_\_\_ **Yes No** Poor Healing \_\_\_\_\_

**Yes No** Diabetes \_\_\_\_\_ **Yes No** Psychiatric or "nerve" problems \_\_\_\_\_

**Yes No** Thyroid problems \_\_\_\_\_ **Yes No** Excessive Scarring \_\_\_\_\_

**Yes No** Arthritis \_\_\_\_\_ **Yes No** Tuberculosis \_\_\_\_\_

**Yes No** Excessive bruisability \_\_\_\_\_ **Yes No** Heart Murmur \_\_\_\_\_

Do you have a history of bleeding?

**Yes No** From the nose \_\_\_\_\_ **Yes No** In the Urine \_\_\_\_\_ **Yes No** From the Rectum \_\_\_\_\_

**Yes No** Coughing up blood \_\_\_\_\_ **Yes No** Vomiting \_\_\_\_\_ **Yes No** Other \_\_\_\_\_

**Yes No** Do you bruise easily? \_\_\_\_\_

Have you ever had any of the following surgeries? Date and Procedure?

Sinus Surgery \_\_\_\_\_ Skin Surgery \_\_\_\_\_

Tonsillectomy \_\_\_\_\_ Breast Surgery \_\_\_\_\_

Adenoidectomy \_\_\_\_\_ Fracture Repair \_\_\_\_\_

Chest or lung surgery \_\_\_\_\_ Neurologic Surgery (Brain, Spine) \_\_\_\_\_

Dental Surgery \_\_\_\_\_ Abdominal Surgery (ie. Gall Bladder, Intestine) ,Hernia) \_\_\_\_\_

Thyroid Surgery \_\_\_\_\_ Orthopedic Surgery Including f Fractures, Back \_\_\_\_\_

Heart Surgery \_\_\_\_\_ Reproductive System (Hysterectomy, D&C) \_\_\_\_\_

Bladder Surgery \_\_\_\_\_ Other \_\_\_\_\_

Were there any complications to any of the above mentioned procedures? \_\_\_\_\_

**Yes No** Have you been advised to have a surgical operation which has not been done? \_\_\_\_\_

**Yes No** Have you had a heart attack? \_\_\_\_\_

**Yes No** Do you have high blood pressure (Hypertension)? \_\_\_\_\_

**Yes No** Do you have frequent pain in the chest? \_\_\_\_\_

**Yes No** Do you have stomach trouble or ulcers? \_\_\_\_\_

**Yes No** Do you have problems with your blood sugar levels (Diabetes, Hypoglycemia)? \_\_\_\_\_

- Yes No** Do you have problems with scarring? (Hypertrophic or Keloid) \_\_\_\_\_
- Yes No** Have you had Hepatitis? **Type A Type B** (circle) \_\_\_\_\_
- Yes No** Have you ever been treated for cold sores? \_\_\_\_\_
- Yes No** Do you have or have you had chest or lung problems? \_\_\_\_\_
- Yes No** Have you ever had liver, gall bladder trouble or "yellow jaundice"? \_\_\_\_\_
- Yes No** Do you have hay fever, nasal allergies or asthma? \_\_\_\_\_
- Yes No** Do you have or have you had any problems with your eyes? \_\_\_\_\_
- Yes No** Do you suffer from arthritis? **Rheumatoid or Osteo** (circle) \_\_\_\_\_
- Yes No** Do you have frequent skin infections, irritations or rashes? (circle) \_\_\_\_\_
- Yes No** Do you have severe headaches or dizzy spells? \_\_\_\_\_
- Yes No** Has any part of your body ever been paralyzed or numb? \_\_\_\_\_
- Yes No** Have you ever had a convulsion or , seizure or stroke? \_\_\_\_\_
- Yes No** Have you ever been treated for a sexually transmitted disease? \_\_\_\_\_
- Yes No** Are you allergic to latex (latex gloves)? \_\_\_\_\_
- Yes No** Have you taken steroids within the past year? \_\_\_\_\_
- Yes No** Were you ever been treated for anemia or any problems with your blood? \_\_\_\_\_
- Yes No** Have you ever received a blood transfusion? \_\_\_\_\_
- Yes No** Have you ever had a positive blood test for HTLV III or HIV (AIDS)? \_\_\_\_\_
- Yes No** Have you ever taken hormones or thyroid medications? \_\_\_\_\_
- Yes No** Do you smoke cigarettes, cigars, or a pipe? How much? \_\_\_\_\_
- Yes No** Are you an ex-smoker? When did you stop smoking? \_\_\_\_\_
- Yes No** Do you drink more than 3 cups of caffeinated drinks a day? How much? \_\_\_\_\_
- Yes No** Do you regularly drink more than 2 alcohol drinks a day? How many? \_\_\_\_\_
- Yes No** Have you ever received treatment for abuse of alcohol or drugs? \_\_\_\_\_
- Yes No** Do you use recreational drugs? If so what? \_\_\_\_\_
- Yes No** Do you often get depressed? \_\_\_\_\_
- Yes No** Have you ever been under the care of a psychiatrist or psychologist? Explain: \_\_\_\_\_
- Yes No** Have you had "female" GYN problems? \_\_\_\_\_
- Yes No** Have you ever had prostate problems? \_\_\_\_\_
- Yes No** Do you realize that every operation is followed by a period of healing before the tissue returns to normal and the final result is apparent? \_\_\_\_\_
- Yes No** \* Do you have any other medical problems that have not been covered? \_\_\_\_\_
- Yes No** Have you been told to take antibiotics prior to surgery and/or dental work? \_\_\_\_\_
- Yes No** \* Do you understand that the objective of any cosmetic surgery is improvement in appearance, not perfection? \_\_\_\_\_
- Yes No** We may contact your doctor, c ? \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

The information you have provided to us is essential to our comprehensive evaluation in your case. Please write down any questions you have so that we may discuss them in detail during your consultation period.