

# Confidential Health Questionnaire

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Email Address \_\_\_\_\_

## SOCIAL HISTORY

Current Occupation \_\_\_\_\_ Do you do physical labor?  Yes  No What kind? \_\_\_\_\_

Do you smoke or use tobacco?  Yes  No If Yes, number of packs per day \_\_\_\_\_

Do you drink alcohol?  Yes  No If Yes, amount of alcohol per week \_\_\_\_\_

Do you use drugs or have a history of drug abuse in the past?  Yes  No  
Please Describe \_\_\_\_\_

Do you exercise regularly?  Yes  No  
How much and what type of activity? \_\_\_\_\_

Who will care for you after surgery? \_\_\_\_\_

## FAMILY MEDICAL HISTORY (please explain if any of these conditions have affected a blood relative)

- Cancer: What type? \_\_\_\_\_ who? \_\_\_\_\_
- Blood clotting problems \_\_\_\_\_ who? \_\_\_\_\_
- High blood pressure \_\_\_\_\_ who? \_\_\_\_\_
- Breast Disease \_\_\_\_\_ who? \_\_\_\_\_
- Abnormal reaction to anesthesia \_\_\_\_\_ who? \_\_\_\_\_
- Heart disease (heart attacks, heart bypass surgery) \_\_\_\_\_ who? \_\_\_\_\_
- Any diagnosed genetic condition \_\_\_\_\_ who? \_\_\_\_\_
- Diabetes \_\_\_\_\_ who? \_\_\_\_\_
- Strokes \_\_\_\_\_ who? \_\_\_\_\_
- Other \_\_\_\_\_
- None of these

## PERSONAL MEDICAL INFORMATION

Allergies  None  
 Medications \_\_\_\_\_ Reaction \_\_\_\_\_  
 Environmental \_\_\_\_\_ Reaction \_\_\_\_\_  
 Latex \_\_\_\_\_ Reaction \_\_\_\_\_

Past Medical History (List any past or current medical problems or injuries)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_

Operations, Procedures and Complications (List past or planned operations, including complications)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_

Current Medications and Supplements (including dietary supplements, nonprescription and herbal products).  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Dose \_\_\_\_\_  
\_\_\_\_\_ Dose \_\_\_\_\_  
\_\_\_\_\_ Dose \_\_\_\_\_ (use back if needed)

Do you take any anti-depressants?  Yes  No What type? \_\_\_\_\_  
Do you take Ibuprofen (Advil) or aspirin on a regular basis?  Yes  No How often? \_\_\_\_\_  
Has your weight been stable for the past 6 months or more?  Yes  No

Please explain any changes \_\_\_\_\_

**Bleeding or Blood Clotting Disorders:**

Have you or any blood relative had problems with:

- Abnormal or excessive bleeding
- Abnormal or excessive blood clotting,
- Deep Venous Thrombosis (DVT) or Pulmonary Embolism (PE)
- None of these

Do you have now, or have you been diagnosed as having (if yes, please explain):

Unexpected weight loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous breakdown	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes in appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vision changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bulimia or anorexia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ear, Nose, Throat Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Unexplained infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cold sores around mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pulmonary edema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Irregular or rapid heart beat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	AIDS or HIV positive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina or chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Immune disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart murmurs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Menstrual abnormalities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of rheumatic fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of breath/wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mood disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chronic cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer or tumor	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep apnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Had a blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
CPAP machine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaundice or liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Easy bruising	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach / intestinal bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent heartburn or reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent gum or nose bleeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach or duodenal ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Autoimmune disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea / constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Painful urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood in urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes mellitus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscle disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Varicose veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin changes/mole changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Unsightly/ bothersome scars	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Breast biopsies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sensation changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fibrocystic breast disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Numbness/Tingling	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Any history of problems with anesthesia? Explain: \_\_\_\_\_

**SKIN HEALTH HISTORY**

Do you or have you used any oral or topical skin care products prescribed by a medical provider in the last year? (for example, Accutane, Obagi, Hydroquinone, Retin A, medical grade skin care products)

- Yes
- No
- Which? \_\_\_\_\_

Have you ever been treated by a medical professional for acne?  Yes  No

Please explain \_\_\_\_\_

Do you use a tanning bed?  Yes  No

How often? \_\_\_\_\_ Last use of tanning bed? \_\_\_\_\_

Have you ever been under the treatment of a: Dermatologist \_\_\_\_\_ Plastic Surgeon \_\_\_\_\_ Aesthetician \_\_\_\_\_

What skin care line are you currently using? \_\_\_\_\_

**Females:**

Is there a chance you are pregnant?  Yes  No

Do you take any type of hormone replacement?  Yes  No What type? \_\_\_\_\_

Are you taking a birth control pill or hormone contraception?  Yes  No What type? \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_ Age of children \_\_\_\_\_ Future pregnancies?  Yes  No

Patient Name \_\_\_\_\_

Patient (or Guardian's) Signature \_\_\_\_\_

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_

