

PERSONAL HEALTH QUESTIONNAIRE

MEDICAL EVALUATION:

How is your general health? _____

Are you presently being treated for any medical conditions? Yes / No

If yes, please explain: _____

When was your last physical examination? _____

Primary Care Physician: _____

EYES

Visual Loss (one or both) Yes / No

“Dry” eyes Yes / No

Itching or Irritation Yes / No

Blurred or Double Vision Yes / No

Crossed or Lazy eyes Yes / No

Cornea Problems Yes / No

Thyroid Eye Disease Yes / No

Wear Glasses/Contacts Yes / No

Previous eye/eyelid surgery Yes / No

If yes, explain: _____

NOSE

Difficulty Breathing Yes / No

Previous Injury Yes / No

Nasal Allergies Yes / No

Nose Bleeds Yes / No

Sinus Conditions Yes / No

Previous Nasal/Sinus Surgery Yes / No

If yes, what type: _____

FACE

Previous Aesthetic Surgery Yes / No

If yes, what type: _____

Irradiation to Face or Neck Yes / No

Facial Paralysis / Weakness Yes / No

Facial Skin Problems Yes / No

Other Skin Problems Yes / No

If yes, what type: _____

ALLERGIES

Any Drug Allergies Yes / No

(including local Anesthetic & Codeine)

If yes, Drug & Reaction: _____

CARDIOVASCULAR

Coronary or Heart Attack Yes / No

Congenital Heart Disease Yes / No

Heart Murmur Yes / No

Palpitations/Irregular Beat Yes / No

Hypertension Yes / No

Stroke Yes / No

CHEST

Shortness of Breath Yes / No

Chronic Lung Disease Yes / No

Cough Yes / No

Asthma Yes / No

BREAST

Pain or Discomfort Yes / No

Cysts or Lumps Yes / No

Have you had Biopsies Yes / No

Breast Cancer in Family Yes / No

If yes, who: _____

Recent Mammogram Yes / No

If yes, when: _____

PSYCHIATRIC

Have you received treatment Yes / No

If yes, were you hospitalized Yes / No

Any recent crisis in your life Yes / No

OTHER

Liver Disorder Yes / No

Hepatitis / Cirrhosis Yes / No

Kidney / Bladder Disorders Yes / No

Chronic Infections Yes / No

Spinal or Back Disorders Yes / No

Previous Blood Clots Yes / No

Previous Thrombophlebitis Yes / No

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MEDICATIONS

List any medications and dosage you are taking or have taken within the last month:

Do you take Aspirin or medication that contains Aspirin Yes / No

Taken a Steroid (Cortisone) over the past year Yes / No

Taking Vitamin E Yes / No

FAMILY HISTORY

History of Medical Problems or Illness

Mother: _____

Father: _____

Sister: _____

Brother: _____

SURGERY (operations)

Type	Date	Complications or Difficulties
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

ADMISSIONS TO HOSPITALS

Reason	Date	Complications or Difficulties
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

WHAT COSMETIC SURGERY & CONCERNS WOULD YOU LIKE TO DISCUSS?

OTHER (Continued)

Bleeding Disorders – Self Yes / No

Bleeding Disorders – Family Yes / No

Blood Transfusions Yes / No

Diabetes Yes / No

Autoimmune Disease Yes / No

Lupus, Rheumatoid Arthritis Yes / No

Keloids or Unusual Scarring Yes / No

Are you Pregnant Yes / No

Stomach / Digestive Disorder Yes / No

Thyroid Problem Yes / No

SOCIAL

Do you Smoke Yes / No

If so, How many per day: _____

Alcohol Consumption Yes / No

Drinks per day: _____

CHILDHOOD MEDICAL HISTORY

Had All Known Baby Shots Yes / No

Polio Immunization Yes / No

Rheumatic Fever Yes / No

CURRENT HEIGHT: _____

CURRENT WEIGHT: _____

Patient Signature: _____

Date _____