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**Facial Plastic Surgery**

**7373 France Ave S**

**Ste 508**

**Edina, MN 55435**

**MEDICAL HISTORY**

Please Fill in Completely

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Patient Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

2. Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male  Female 

3. Name and address of primary physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Date of last examination:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Are you under the care of a physician? Yes  No 

If yes, for what reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. List all medication(s), drugs or herbal supplements you are presently taking:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name: | Dose: | Date Started: | Reason for Taking: |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

7. Do you use tobacco or smoke? Yes  No 

8. What surgeries have you had and/or have you been advised of the need for any type of surgery?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. (Women) Are you pregnant? Yes  No  If yes, how long?\_\_\_\_\_\_\_\_\_

10. Do you have any allergies? Yes  No  If yes, please list all allergies:

Penicillin  Latex  Local Anesthetic  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Do you have, or have you ever had:

Heart Disease Yes No High Cholesterol Yes No

Circulatory problems Yes No Anemia Yes No

Heart Murmur Yes No Arthritis Yes No

Rheumatic fever Yes No Asthma or hay fever Yes No

Congenital heart defects Yes No Back problems Yes No

Abnormal blood pressure Yes No Chemical dependency Yes No

Diabetes Yes No Fainting spells Yes No

Excessive urination or thirst Yes No Glaucoma Yes No

Seizure disorder Yes No Headaches (frequent) Yes No

Exposure to the AIDS virus Yes No Jaundice Yes No

Excessive or prolonged bleeding Yes No Anxiety Yes No

Stroke Yes No Cancer Yes No

Page 1 of 2 Initials: \_\_\_\_\_\_\_\_

Prosthetic implant Yes No Specific Type & Treatment \_\_\_\_\_\_\_\_

Tuberculosis or lung disease Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis - Type\_\_\_\_\_\_\_ Yes No Sinus trouble Yes No

Strep Throat When\_\_\_\_\_\_\_ Yes No Thyroid problem Yes No

Sexually transmitted disease Yes No Tonsillitis Yes No

Herpes Simplex (Cold Sores) Yes No Ulcers Yes No

If you answered yes to any of these questions please explain here\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Have you had any other serious illness, hospitalization or accident? Yes No

13. Is there anything else we should know about your medical history?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_

Recorded by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.D. Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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