



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 <input type="checkbox"/> | No <input type="checkbox"/> | High Cholesterol | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Circulatory problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Anemia | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart Murmur | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Arthritis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Rheumatic fever | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Asthma or hay fever | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Congenital heart defects | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Back problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Abnormal blood pressure | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Chemical dependency | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Fainting spells | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Excessive urination or thirst | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Glaucoma | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Seizure disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Headaches (frequent) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Exposure to the AIDS virus | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Jaundice | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Excessive or prolonged bleeding | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Anxiety | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Stroke | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Cancer | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Prosthetic implant	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Specific Type & Treatment _____
Tuberculosis or lung disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Hepatitis - Type _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sinus trouble Yes <input type="checkbox"/> No <input type="checkbox"/>
Strep Throat When _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thyroid problem Yes <input type="checkbox"/> No <input type="checkbox"/>
Sexually transmitted disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tonsillitis Yes <input type="checkbox"/> No <input type="checkbox"/>
Herpes Simplex (Cold Sores)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ulcers Yes <input type="checkbox"/> No <input type="checkbox"/>

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 _____