Facial Plastic Surgery
4999 France Ave S
Ste 210
Minneapolis, MN 55410

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☐

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_____