California Institute of Cosmetic & Reconstructive Surgery
Vipul R. Dev, M.D., Narayanan M. Nair, M.D.
Health Questionnaire

Patient Name: ____Date: _________________________

The following questions regarding your health have been carefully selected as pertinent to your care. Please answer to the best of your ability.

Referring Physician: _____________________________ Reason for Visit: ____________________________________

Is there a History of this problem? ☐ No ☐ Yes ____

Is this a surgical problem? ☐ No ☐ Yes ____

Are you in pain? ☐ No ☐ Yes If yes, what makes the pain worse? ____

How long have you had this problem? ____

HAVE YOU EVER BEEN DIAGNOSED FOR:

❑ High Blood Pressure ❑ Tuberculosis ❑ Coronary Disease ❑ Rheumatic Fever ❑ Diabetes ❑Valley Fever

❑Hepatitis A ❑Hepatitis B ❑Hepatitis C ❑ Emphysema

Do you have any reason to believe you may have been exposed to the HIV virus (AIDS) (i.e. blood transfusion, drug use, lifestyle, etc.)
❑Yes ❑No

MEDICATIONS:

Have you ever taken medications for your heart? ❑Yes ❑No
Have you ever had a general anesthetic? ❑Yes ❑No If yes, when? _________________________________
And did you have any problems? ❑Yes ❑No If yes, explain _________________________________

Are you ALLERGIC to any medications or hospital products, including: tape, iodine, latex, etc.?
❑Yes ❑No **If yes, please list what meds. and include what reactions you have?**

____

LIST ALL MEDICATIONS YOU HAVE TAKEN WITHIN THE PAST TWO WEEKS. Include Vitamins, Oral Contraceptives, Supplements, Eye Drops, Skin Ointments, Cold Tablets, Headache Meds. If you are no longer taking the medications, list when you stopped**.**

If NONE, check here ❑

Medications	Reason for Taking	Dosage & Frequency

PERSONAL HISTORY:

Age: ______________________ Height: ___________________ Current Weight: ____________________________________

What is the most you have ever weighed? ___________________ Your weight one year ago? ______________________________

When was your last Chest X-Ray? Date: ___________________ Location: ____

When was your last EKG? Date: __________________________ Location: ____

Have you ever had a Blood Transfusion? ❑Yes ❑No

PREVIOUS COSMETIC SURGERIES/PROCEDURES:

❑Yes ❑No

Please Check all that Apply & Date of Surgery:

❑Breast Augmentation: ❑Silicone ❑Saline Date(s): ___________________

❑Breast Reduction Date:______________________________ ❑Breast Lift Date: _________________________________

❑Breast Revision Date: ______________ ❑ Other Breast Surgery:______________________ Date:___________________

❑Liposuction What areas? ____ Date: __________________

❑Tummy Tuck Date: __________________ ❑Butt Augmentation Date: ____

❑Arm Lift Date: _____________________ ❑Thigh Lift Date: ____

❑Body Lift Date: _____________________ ❑Upper or Lower Eyelid Lift Date: __________________________________

❑Facelift Date: _____________________ ❑Rhinoplasty (Nose Reshaping) Date: _________________________________

❑Facial Implants Where/What: _____________________________ Date: ____

❑Brow Lift Date: ____________________________________ ❑Neck Lift Date: ____________________________________

❑Ear Reshaping Date: ________________ ❑Scar Revision to Where? _______________________ Date: ______________

❑Other Cosmetic/Plastic Surgeries: ____ Date: ______________

NON Surgical Treatments

❑ Botox Last Treatment Date: __________________________ ❑Thread Lift Date: _________________________________

❑Dermal Fillers (Juvederm, Restyling, etc.): ____ Date: _________________

❑Fat Injections Where? ________________ Date___________________ ❑Chemical Peel Date: __________________

❑Any Laser Treatments Where? ________________________________ Date of Last Treatment: ______________________

❑Microdermabrasion Date: ___________________________ ❑Dermabrasion Date: _________________________________

❑Other: ____ Date: __________________

PAST SURGERIES: Please list all surgeries you have ever had. **If NONE, check here** ❑

Surgery	Year	Facility, Surgeon/Dr.

PHYSICAL HABITS:

Can you run up a flight of stairs? ❑Yes ❑No

Can you walk up a flight of stairs? ❑Yes ❑No

How far can you walk? ____

Are you physically active? (this includes any house work, yard work etc.) ❑Yes ❑No

SOCIAL HISTORY:

Do you drink alcohol? ❑Yes ❑No If yes, how often? ______________________________

Smoking: ❑ Never Smoked ❑ Currently Smoking (_______ packs per day) ❑ Quit Smoking (_________yrs./mon ago)
❑ Socially ❑ Nicotine Patch

Do you use street drugs? ❑Yes ❑No
If yes, what? How often? How Recent? ______________________________

FEMALE HISTORY:

When was your last Mammogram? Date: __________________ Location: ______________________________

Are you pregnant? ❑Yes ❑No If yes, number of months: ______________________________

Number of pregnancies: ______________ Births _______________ Other Important Info: ______________________________

Date of last menstrual period/or onset of menopause______________________________

Personal History of Breast Cancer? ❑ Yes ❑ No If yes, date(s) diagnosed? ______________________________

Family History of Breast Cancer? ❑ Yes ❑ No If yes, who & age at diagnosis: Mother______________________________

Sister(s)__________________________ Aunt(s)____________________________ Grandmother(s)______________________

SKIN HISTORY:

Have you ever seen a Dermatologist for your skin? ❑Yes ❑No If yes, for what? ______________________________

Do you currently, or have you ever used any topical medications on your skin? (this includes any Salicylic, Glycolic, Lactic Acids or Retin A products)
❑Yes ❑No If yes, what meds.? ______________________________

If you have in the past when did you stop usage? ______________________________

Have you ever used Accutane? ❑Yes ❑No If yes, when was the last dose? ______________________________

Do you form thick or raised scars? ❑Yes ❑No

SYSTEMS REVIEW:

Please circle the following disease or symptoms you have or have had in the past. If yes, briefly explain.
General (Recent Appetite Change, Fatigue, Weakness, Fever, Unusual Sleeping Habits)

❑None If yes, ______________________________

Skin (Rashes, Sores, Bruising, Hair Loss, Itching, Lesions, Keloid Scars, Hives, Acne, Night Sweats, Skin Disease)

❑ None If yes, ______________________________

Hearing, Eyes, Nose, Throat (Migraines, Hearing Changes, Nose Bleeds, Sore Throat, Hoarseness, Sinus Problems)

❑ None If yes, ______________________________

Do you wear Eye Glasses or Contact Lenses? ❑Yes ❑No

Breasts (Pain, Discharge, Enlargement, Lumps)

❑None If yes, ______________________________

Respiratory (Pneumonia, Emphysema, Chest Pain, Shortness of Breath, Cough, COPD)

❑None If yes, ______________________________

Cardiovascular (Heart Disease, Angina, Palpitations, Stroke, Arrhythmias, Hypertension, Murmur, CAD)

❑None If yes, ______________________________

Gastrointestinal (Nausea, Vomiting, Jaundice, Diarrhea, Constipation, Indigestion, Bloody Stools, Abdominal Pain, Liver Disease, Cirrhosis, Gallbladder Disease, Colitis/Bowel Disease)

❑None If yes, ______________________________

Genitourinary (Bloody Urine, Pain on Urination, Stones, Urinary Infections, Increased Urinary Frequency)

❑None If yes, ______________________________

OB/GYN (Pain on Menstruation, Discharge, Infection, Intermenstrual Bleeding, Menopause)

❑None If yes, ______________________________

Musculoskeletal (Arthritis, Fractures, Dislocations, Weakness, Varicose Veins, Back Problems, Swelling of Hands & Feet)

❑None If yes, ______________________________

Neurologic (Vertigo, Headaches/Migraines, Syncope, Seizures, Paralysis, Loss of Memory, Stroke, Numbness, Polio, Meningitis, Dizziness, Convulsions or Epilepsy, Neuritis)

❑None If yes, ______________________________

Hematologic (Excessive Bleeding, Easy Bruising, Swollen Lymph Nodes, Recurrent Infections, Hay Fever, Anemia)

❑None If yes, ______________________________

Endocrine (Thyroid Disease, Obesity, Gynecomastia, Hot/Cold Intolerance, Nervousness)

❑None If yes, ______________________________

Psychiatric (Depression, Anxiety, Suicide Ideation, Hallucinations)

❑None If yes, ______________________________

Do you have or ever had any **Cancer(s)**? ❑Yes ❑No If yes, what type(s)? ______________________________

Have you ever had a Head Injury or a Concussion? ❑Yes ❑No If yes, ______________________________

FAMILY HISTORY:			
FAMILY MEMBER	**AGE**	**ALIVE/DECEASED**	**MEDICAL CONDITIONS**
MOTHER			
FATHER			
SISTER (S)			
BROTHER (S)			

Preferred Pharmacy:

Name:

____

Phone:

____

Address/Location:

____

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any of his staff members responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: ______________________________ **Date:** ______________________________