DESERT HILLS
PLASTIC SURGERY CENTER
10001 South Eastern Avenue, Suite 406
Henderson, Nevada 89052

Patient Information and Health History

Patient Name:_____

Date of Birth: _____ Age: _____

Email address:_____

Referred By:_____

Primary Care Doctor:_____

Reason for Visit:_____

List Medical Problems or Illnesses:_____

_____

_____

List **All** previous Cosmetic Surgeries or Procedures (with relevant dates if known):_____

_____

List **All** other Surgeries

_____

_____

Have you ever had problems or complications associated with previous surgery or anesthesia? Yes No (circle one). If yes, describe:

_____

_____

List any medications you are taking, including vitamins or herbal medicines:_____

_____

List any allergies to any medicines or materials: _____

_____

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PAST MEDICAL HISTORY

Have you ever had any of the following? (Please circle the appropriate response)

Heart Disease	Yes	No	Heartburn/reflux	Yes	No
Lung Disease	Yes	No	Mitral Valve Prolapse	Yes	No
Diabetes	Yes	No	Breathing Difficulties	Yes	No
MRSA(Staph Infections)	Yes	No	Cold Sores	Yes	No
High Blood Pressure	Yes	No	Varicose Veins	Yes	No
Asthma	Yes	No	Joint Replacement	Yes	No
Blood Clots in legs	Yes	No	Skin Cancer	Yes	No
Shingles	Yes	No	If (Yes), Where?_____		
Accutane use	Yes	No	Arthritis	Yes	No
HIV or Aids	Yes	No	Thyroid Disease	Yes	No
Hepatitis	Yes	No	Kidney Disease	Yes	No
Stroke	Yes	No	Inflammatory Bowel Disease	Yes	No
Mental Illness	Yes	No	Addiction/Substance Abuse	Yes	No

FAMILY HISTORY

Have any of your relatives had any of the following? (Please circle the appropriate response)

Breast Cancer	Yes	No	Addiction/Substance Abuse	Yes	No
Melanoma	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Mental Illness	Yes	No
High Blood Pressure	Yes	No	Bleeding Disorder	Yes	No
Blood clots (DVT)	Yes	No	Cancer	Yes	No
Diabetes	Yes	No	If so, what kind? _____		
Kidney Disease	Yes	No	Any other? _____		

OPHTHALMOLOGIC HISTORY

Do you have any of the following?

Abnormal Visual Acuity	Yes	No	Near or Farsighted (*please circle one*)	Yes	No
Glasses	Yes	No	Dry Eyes	Yes	No
Contacts	Yes	No	Edema	Yes	No
Glaucoma	Yes	No	Cataracts	Yes	No
Visual Field Disturbance	Yes	No	Tearing	Yes	No
Facial Muscle/Nerve Problems	Yes	No	Allergies	Yes	No
Previous Eye Surgery	Yes	No			
If yes, what kind?_____					

REVIEW OF SYSTEMS

Have you had any of the below listed symptoms in the past year?

Fever & Chills	Yes	No	Abdominal Pain	Yes	No	Swollen Feet	Yes	No
Skin Lesion/Rash	Yes	No	Chronic Cough	Yes	No	Constipation	Yes	No
If yes, where:_____			Headache	Yes	No	Heartburn or Reflux	Yes	No
Dry Eyes	Yes	No	Sore Throat	Yes	No	Breast Lump	Yes	No
Ear Infection	Yes	No	Taken Steroids	Yes	No	If (Yes) Where_____		
Sinusitis	Yes	No	Depression	Yes	No	Any Biopsy?_____		
Joint or Muscle Pain	Yes	No	Easy Bruising or Bleeding	Yes	No	Seizures	Yes	No
If (Yes) Where_____			Wheezing	Yes	No	Wear Contact Lenses	Yes	No
Urinary Infection	Yes	No	Anxiety	Yes	No	Keloid Scarring	Yes	No
Back Pain	Yes	No	Neck Pain	Yes	No	Dentures	Yes	No
Hypertrophic Scarring	Yes	No	Pigmented (dark) scars	Yes	No	Skin sensitivity	Yes	No
Breast Pain	Yes	No	Severe allergies	Yes	No	Motion Sickness	Yes	No
Chest Pain	Yes	No	Acne/frequent breakouts	Yes	No	Nausea with Medications/ Anesthesia	Yes	No

Weight Change / Gain _____ Loss _____ Current Weight_____ Height _____

Ethnicity_____ What is your Ideal/Realistic Weight?_____

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SOCIAL HISTORY

Job Description: _____

Employer: _____

Do you or did you ever smoke cigarettes? Yes No If so, how many packs per day? _____

When did you quit? _____

Alcohol Use? Yes No # of Alcohol drinks per week? _____

Recreational Drug use? Yes No What kind? _____

Cannabinoids (Marijuana) use? Yes No What Kind? _____ (Smoke or edible)

How often? _____ Other _____

Married Or Single (circle one)

Exercise Routine: _____

Dietary Habits/Preferences: _____

Hobbies or Activities you enjoy: _____

Do you have any special events coming up that you want to look great for? (for example, reunion, wedding, trip)

_____

When is the event?_____

What are the top two things you like least about your body?_____

What are the top two things you like least about your face?_____

WOMEN ONLY

Number of pregnancies _____ Number of children _____

Any problems or complications with previous pregnancy? Yes No

Any history of unexplained stillborn, more than 3 miscarriages, or premature birth with toxemia or growth-restricted infant? Yes No

If yes, describe: _____

Date of last menstrual period _____

Date of last Mammogram (xray) study_____

Did you breast feed? Yes No, Do you do regular breast self- examinations? Yes No

Are you planning on more children? Yes No, Do you want to breast feed more children? Yes No

SKIN EVALUATION *What best characterizes your skins reaction to sun exposure (without sunscreen). Check the most appropriate response.*

_____ 1) Always burns, never tans
_____ 2) Usually burns, tan with difficulty
_____ 3) Sometimes mildly burns, tans average
_____ 4) Rarely burns, tans with ease

Describe your current facial/skin care regimen:

_____

NON-SURGICAL TREATMENTS ***Have you had any of the following? Yes or No***

Botox/Dysport/Xeomin Yes No If yes, when was your last treatment? _____

How long did it last? ____months.

FILLERS ***Have you had any of the following? Yes No***

Belotero Yes No What area? _____When was your last treatment?_____

Radiesse Yes No What area?_____ When was your last treatment?_____

Voluma Yes No What area? _____ When was your last treatment?_____

Bellafil/Artefill Yes No What area? _____When was your last treatment?_____

Restylane Yes No What area? _____When was your last treatment?_____

Sculptra Yes No What area? _____When was your last treatment?_____

Juvederm Yes No What area? _____ When was your last treatment?_____

Fat Injections Yes No What area?_____

Other Injectable Material Yes No What kind? _____

Location? _____ When? _____

SKIN RESURFACING ***Have you had any of the following? Yes No***

Laser Treatments Yes No If yes, what kind? _____ When?_____

Chemical Peels Yes No If yes, what kind? _____ When?_____

Surgical Dermabrasion (not microdermabrasion) Yes No If yes, when?_____

WHAT COSMETIC SURGERY PROCEDURES HAVE YOU DONE BEFORE AND **LIKED?**

_____

_____

WHAT COSMETIC SURGERY PROCEDURES HAVE YOU DONE BEFORE AND **DISLIKED?**

_____

WHAT ARE YOU INTERESTED IN TRYING?

_____

WHEN DO YOU WANT TO DO SURGERY OR YOUR PROCEDURE? (CHECK ONE)

____ As soon as possible ____ One week _____ One month ____ Two months _____ 4 months _____ 6 months

_____ A particular date or season (please name):_____

WHAT IS YOUR BUDGET OR HOW MUCH DO YOU WANT TO SPEND? $_____

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CONTACT INFORMATION

I wish to be contacted in the following manner (check that apply):

( ) Home telephone _____
( ) o.k. to leave message or talk to other family members about my medical condition.

( ) Work number _____
( ) Leave message with call back number only

( ) Cell telephone _____
( ) o.k. to leave message with detailed information.

( ) Email Address: _____

_____ _____
Signature Date

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FOR OFFICE USE ONLY: HISTORY REVIEWED BY: DATE: