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:

_____

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**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

==========

FOR OFFICE USE ONLY: HISTORY REVIEWED BY: DATE: