



Florence Mussat M.D.,S.C.

PATIENT MEDICAL HISTORY INFORMATION

Date _____

Name _____ Age _____ Ht _____ Wt _____

Occupation _____

How were you referred to us? _____

For what reasons are you seeking consultation today? _____

OPERATIONS

What cosmetic procedures, if any, have you had? _____

What other operations have you had? _____

Were there any complications? _____

Were there any anesthetic complications? _____

ALLERGIES

Are you allergic to any medications?-----> Yes -----> No

If yes, list drug and reaction type _____

Tape allergy-----> Yes -----> No

MEDICATIONS

What medications are you presently taking and what are the dosages? _____

Do you take aspirin or medications containing aspirin?-----> Yes -----> No

Have you taken any steroid preparations in the past year?-----> Yes -----> No

Do you use inhalers or nasal sprays?-----> Yes -----> No

MEDICAL HISTORY

How is your general health? _____

Have you had any significant weight changes over the past ten years? _____

If yes, how much gain or loss over how long a period of time? _____

Are you presently being treated for any medical condition? _____

If yes, what condition? _____

When was your last physical examination? _____

Please list your physicians and their specialties _____

REVIEW OF SYSTEMS

Face and Neck

- Irradiation to the face or neck-----> Yes -----> No
- Facial Paralysis or weakness-----> Yes -----> No
- Skin problems (acne, cancers, etc.)-----> Yes -----> No

If yes, which problems? _____

- Thyroid disease -----> Yes -----> No
- Do you wear dentures?-----> Yes -----> No

Eyes

- Visual loss (one or both eyes)-----> Yes -----> No
- Dry or scratchy eyes-----> Yes -----> No
- Itching or irritation of eyes-----> Yes -----> No
- Blurred or double vision-----> Yes -----> No
- Crossed or lazy eyes-----> Yes -----> No
- Corneal problems-----> Yes -----> No
- Cataracts-----> Yes -----> No
- Do you wear contacts or glass -----> Yes -----> No

Nose

- Difficulty breathing through nose-----> Yes -----> No
- Previous injury or fracture to nose-----> Yes -----> No
- Nasal allergies-----> Yes -----> No
- Nose bleeds-----> Yes -----> No
- Sinus conditions-----> Yes -----> No

Cardiovascular

- Chest pain-----> Yes -----> No
- Heart Attack-----> Yes -----> No
- Congenital heart disease-----> Yes -----> No
- Rheumatic fever in past-----> Yes -----> No
- Heart Mumur-----> Yes -----> No
- Palpitations or irregular heart beat-----> Yes -----> No
- High blood pressure-----> Yes -----> No
- Stroke-----> Yes -----> No
- Mitral valve prolapse-----> Yes -----> No
- Heart failure-----> Yes -----> No
- Other-----> Yes -----> No

Chest

- Shortness of breath-----> Yes -----> No
- Chronic lung disease-----> Yes -----> No
- Asthma-----> Yes -----> No
- Breast tumors or disease-----> Yes -----> No

If female, when was your last mammogram? _____

Other

- Tumors-----> Yes -----> No

Previous blood clots or thrombophlebitis -----> Yes -----> No
 Bleeding disorders or easy bruising-----> Yes -----> No
 Anemia-----> Yes -----> No
 Blood in urine or stool-----> Yes -----> No
 Blood transfusion in past-----> Yes -----> No

If yes, when?_____

Liver disorder including hepatitis or cirrhosis-----> Yes -----> No
 Abdominal Pain or ulcer-----> Yes -----> No
 Kidney or bladder disorders or frequent infections-----> Yes -----> No
 Spinal or back disorders-----> Yes -----> No
 Diabetes-----> Yes -----> No
 Autoimmune diseases (lupus, rheumatoid arthritis, scleroderma, etc.)-----> Yes -----> No
 Osteoarthritis-----> Yes -----> No
 Headaches or migraines-----> Yes -----> No
 Blackouts or epilepsy-----> Yes -----> No
 Paralysis or nerve disorder-----> Yes -----> No
 Thick scars or keloids-----> Yes -----> No
 AIDS or AIDS related diseases-----> Yes -----> No
 If female, are you pregnant now-----> Yes -----> No

how many pregnancies in the past?_____

how many children?_____

Did you breast feed?-----> Yes -----> No

Pertinent medical information not already mentioned _____

Psychiatric

Have you ever received psychiatric treatment?-----> Yes -----> No

If yes, were you hospitalized?-----> Yes -----> No

Has there been any recent crisis in your life?-----> Yes -----> No

Social History

Are you married?-----> Yes -----> No

How many children do you have?_____

If you are not married, are divorced

widowed
 always been single

Do you live alone?-----> Yes -----> No

Is there someone who can help you after surgery if needed?-----> Yes -----> No

Do you smoke now?-----> Yes -----> No

If yes, number of packs per day_____

Have you ever smoked in the past?-----> Yes -----> No

If yes, when did you quit?-----> Yes -----> No

Do you have more than two drinks per day?-----> Yes -----> No

Aesthetic Surgery

Why do you want surgery? _____

What do you think cosmetic surgery will do for you? _____

How long have you been considering cosmetic surgery? _____

Have you discussed surgery with friends, family or other physicians? _____

If yes, are they supportive or trying to dissuade you from surgery? _____

List below any specific questions you would like to have answered during your
consultation: _____

My time frame is:

_____ As soon as possible

_____ 1 - 3 months from now

_____ 4 - 6 months from now

_____ 7 - 12 months from now

_____ Undecided

I hereby state that the information furnished above has been answered to best of my knowledge.

signature