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____
____
____
____

680 North Lake shore Drive Suite 1030 Chicago, IL 60611
office (312) 751-9000 fax (312)868-3700
fmussatmd@msn.com

___

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