Avante Plastic Surgery

Health History

Name Age Date Height Weight Sex PCP

Medical Problems

Medications (including vitamins and herbals)

Surgeries and Procedures (including cosmetic)

	Yes	No	
Have you or a family member had a problem with anesthesia ?	☐	☐	
Do you have difficulty swallowing pills?	☐	☐	
Have you had problems with prior surgeries?	☐	☐	Explain
Do you have any allergies (drug, Latex, tape, dye)?	☐	☐	List
Have you ever or do you now smoke?	☐	☐	How much and for how long
Do you have a cold, cough or have any breathing difficulty?	☐	☐	
Do you have asthma?	☐	☐	When was your last episode
Do you have sleep apnea or use a CPAP machine?	☐	☐	
Do you have high blood pressure?	☐	☐	For how long
Do you have a heart murmur or mitral valve prolapse?	☐	☐	
Have you ever had an abnormal EKG?	☐	☐	
Have you ever had angina or a heart attack?	☐	☐	
Do you ever wake up short of breath or have swelling over your shins?	☐	☐	
Do you have difficulty walking up two flights of stairs without becoming short of breath?"	☐	☐	
Do you have “hardening of your arteries”?	☐	☐	
Have you ever had kidney disease or require a special diet due to your kidneys?"	☐	☐	
Have you ever had hepatitis or been jaundiced?	☐	☐	
Do you have HIV?	☐	☐	
Do you have a hiatal hernia, acid reflux, or an ulcer?	☐	☐	
Do you have frequent loose bowel movements?	☐	☐	How many per day
Do you drink alcohol?	☐	☐	How much and how often
Have you ever had a stroke?	☐	☐	
Do you have a limb that becomes weak or numb?	☐	☐	
Have you ever had seizures, loss of vision or speech?	☐	☐	
Do you have diabetes?	☐	☐	Do you take ☐ insulin ☐ pills
Do you have thyroid disease?	☐	☐	
Do you have back, neck, or jaw problems?	☐	☐	
Do you have any bleeding disorders?	☐	☐	
Do you have anemia (low blood count)?	☐	☐	
Have you taken aspirin, Coumadin, Plavix or Lovenox in the last week?	☐	☐	
Have you taken any diet medications in the last month?	☐	☐	
Have you had any disease requiring chemotherapy or radiotherapy?	☐	☐	
Do you have children?	☐	☐	Ages
Is there any chance you could be pregnant?	☐	☐	Date of last period
Are you planning to become pregnant in the future?	☐	☐	
Have you or a family member had breast cancer?	☐	☐	Relationship
Have you had a mammogram?	☐	☐	Date Result
Have you ever used illicit drugs?	☐	☐	List
Do you get cold sore/fever blisters?	☐	☐	
Do you have vaginal herpes?	☐	☐	
Have you taken Accutane in the past year?	☐	☐	
Do you have a history of ADD, OCD, depression, anxiety,bipolar disorder, or schizophrenia?	☐	☐	Treating physician
Do you have any other medical or psychiatric problems not listed already	☐	☐	List

Patient Signature