HEALTH HISTORY

Avante Plastic Surgery

Name	Age	Height	Weight	Sex	Primary Care Physician

Medical Conditions: _____

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 (drugs/medications, latex, tape, dye)?	○	○	List: _____
Have you ever or do you now smoke, vape, or use tobacco?	○	○	How much & for how long? _____
Do you have a cold, cough, or have any breathing difficulty?	○	○	
Do you ever been diagnosed with asthma or bronchitis?	○	○	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, angina, or a heart attack?	○	○	
Have you ever had a blood clot (DVT) or pulmonary embolism?	○	○	
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 or diarrhea?	○	○	How many per day? _____
Do you drink alcohol?	○	○	How much & 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 anemia (low blood count) or any other bleeding disorders?	○	○	
Have you been vaccinated for COVID-19?	○	○	
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: _____
Have you been diagnosed with cold sores/fever blisters or vaginal herpes?	○	○	
Do you use birth control or have any implanted birth control devices (IUD, Pellets, etc.)?	○	○	List: _____
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 conditions not listed already?	○	○	List: _____

Patient Signature: _____ Date: _____

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