MEDICAL/SURGICAL HISTORY

TO BE COMPLETED BY PSCON NURSE:

WEIGHT:_____ BLOOD PRESSURE: _____ DATE/INITIALS: _____

TO BE COMPLETED BY PATIENT:

HEIGHT: _____ WEIGHT: _____ IS YOUR WEIGHT STABLE? YES / NO

PLEASE LIST ALL MEDICATIONS, CURRENT OR TAKEN IN THE LAST 6 MONTHS, INCLUDING OVER THE COUNTER MEDICATIONS / VITAMINS / HERBALS / DIET SUPPLEMENTS

MEDICATIONS: DOSAGE/AMOUNT: FREQUENCY:

LIST ALL DRUG ALLERGIES: _____

ARE YOU A SMOKER: YES / NO **EX-SMOKER?** YES / NO **QUIT WHEN? _____**

HOW MUCH ARE (WERE) YOU SMOKING? _____ HOW LONG? _____

PLEASE CIRCLE ALL CURRENT AND/OR PAST MEDICAL CONDITIONS, IF APPLICABLE:

High blood pressure	breast cancer	skin cancer	bleeding tendency	hepatitis	dry eyes
Blood transfusions	diabetes	glaucoma	rheumatoid arthritis	stroke	depression
Irregular heart beat	lung disease	emphysema	asthma or wheezing	mental illness	
Heart disease	heart attack	chest pain	mitral valve prolapse	rheumatic heart disease	
Heart burn	epilepsy	tuberculosis	Intestinal ulcers or bleeding	bronchitis	

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS, SERIOUS ILLNESS, OR INJURY NOT ALREADY LISTED? YES / NO **If YES: _____**

DO YOU HAVE A PRIMARY CARE PHYSICIAN? YES / NO

NAME: _____ **PHONE NUMBER**: _____

HAVE YOU EVER SEEN A CARDIOLOGIST? YES / NO **DATE OF LAST EKG**: _____

NAME: _____ PHONE NUMBER: _____

MEDICAL/SURGICAL HISTORY

DO YOU WORK IN CHILD CARE? YES / NO OCCUPATION: _____

DO YOU WORK IN HEALTH CARE? YES / NO OCCUPATION: _____

DO YOU HAVE ANYONE YOU HELP CARE FOR WHO IS CHRONICALLY ILL, IN AND OUT OF HOSPITALS, NURSING HOMES, OR OTHER CARE FACILITIES: YES / NO

ANY PERSONAL HISTORY OF MRSA INFECTION? YES / NO FAMILY MEMBER? YES / NO

ANY PERSONAL HISTORY OF BLEEDING PROBLEMS? YES / NO FAMILY MEMBER? YES / NO

ANY PERSONAL HISTORY OF CLOTTING PROBLEMS? YES / NO FAMILY MEMBER? YES / NO
(If yes, please circle)
DVT (DEEP VEIN THROMBOSIS) PULMONARY EMBOLISM MTHFR ANTI-PHOSPHOLIPID ANTIBODY FACTOR V LEIDEN

WHEN? _____ NAME OF DOCTOR WHO TREATED YOU: _____

LIST ALL SURGERIES THAT YOU HAVE HAD: (*Include Cosmetic Procedures*) DATE:

HAVE YOU OR ANYONE IN YOUR FAMILY EVER HAD UNUSAL REACTIONS TO ANESTHESIA? YES / NO
(If yes, please circle)
MUSCLE WEAKNESS JAUNDICE BREATHING PROBLEMS UNEXPECTED FEVERS

DO YOU HAVE A HISTORY OF THE FOLLOWING: (If yes, please circle)

BOTOX FILLERS LASER TREATMENTS NON-INVASIVE FAT REMOVAL/COOLSCULPTING

DATE(S) OF LAST TREATMENT(S): _____

_____ _____

PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**

MEDICAL/SURGICAL HISTORY

TO BE COMPLETED BY WOMEN ONLY:

DATE OF LAST MAMMOGRAM: _____ **RESULTS:** NORMAL / ABNORMAL

DO YOU HAVE A FAMILY HISTORY OF BREAST CANCER? YES / NO **WHO?** _____

ARE YOU HERE FOR EVALUATION OF BREAST AUGMENTATION / BREAST LIFT / REDUCTION: YES / NO

If YES: CURRENT BRA SIZE: _____ **WHAT IS YOUR GOAL SIZE? _____**

DO YOU HAVE A GYNECOLOGIST/OBGYN? YES / NO

NAME: _____ **PHONE NUMBER: _____**

DATE OF LAST PELVIC EXAM: _____

HOW MANY CHILDREN HAVE YOU HAD? _____ **BREASTFED?** YES / NO

PERSONAL HISTORY OF MISCARRIAGES? YES / NO **HOW MANY**? _____

PERSONAL HISTORY OF INFERTILITY: YES/NO **KNOWN CAUSE? _____**

DO YOU HAVE CONCERNS REGARDING VAGINAL LAXITY? YES/NO

DO YOU HAVE CONCERNS REGARDING URINARY INCONTINENCE? YES/NO

DO YOU HAVE CONCERNS REGARDING THE EXTERNAL APPEARANCE OF YOUR LABIA? YES/NO

IF YOU CIRCLED YES FOR THE THREE PREVIOUS QUESTIONS, PLEASE DESCRIBE:

_____

_____

DO YOU HAVE A RECENT HISTORY OF TAKING HORMONES OF ANY KIND? YES / NO

IF YES, PLEASE LIST NAME(S): _____

DO YOU HAVE A RECENT HISTORY OF BIRTH CONTROL OF ANY KIND? YES/NO

IF YES, PLEASE LIST NAME(S): _____

_____ _____

PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**