Santa Barbara Plastic Surgery Center

WESLEY G. SCHOOLER, M.D., F.A.C.S. & LESLIE IRVINE, M.D.

Name: _____ Date: ____/_____/_____

# *New Cosmetic Patient Health Questionnaire*

**(Please indicate "Yes" if you have experienced the following symptom in the <u>past 6 months</u>).**

| | | | | | |
|---|---|---|---|---|---|
| **General** | | | | | |
| Chills or fever | O Yes | O No | Weight gain or loss | O Yes | O No |
| **Skin** | | | | | |
| Acne | O Yes | O No | Dry skin | O Yes | O No |
| Rash | O Yes | O No | Discoloration | O Yes | O No |
| New skin moles | O Yes | O No | Eczema | O Yes | O No |
| **Behavioral** | | | | | |
| Anxiety | O Yes | O No | Depression | O Yes | O No |
| Mental or Physical abuse | O Yes | O No | Eating disorder | O Yes | O No |
| **Neurologic** | | | | | |
| Numbness or tingling in hands or feet | O Yes | O No | Memory loss | O Yes | O No |
| Dizziness | O Yes | O No | Fainting or seizure | O Yes | O No |
| **Endocrine** | | | | | |
| Heat or cold intolerance | O Yes | O No | Excessive thirst | O Yes | O No |
| **Eyes** | | | | | |
| Flashes of light in visual field | O Yes | O No | Dry eyes | O Yes | O No |
| Elevated pressure | O Yes | O No | Blurred vision | O Yes | O No |
| **Ear / Nose / Throat** | | | | | |
| Ringing in the ears | O Yes | O No | Sinus pain or infection | O Yes | O No |
| **Allergy** | | | | | |
| Itching or hives | O Yes | O No | Sneezing or watery eyes | O Yes | O No |
| **Respiratory** | | | | | |
| Wheezing | O Yes | O No | Shortness of breath | O Yes | O No |
| **Cardiovascular** | | | | | |
| Shortness of breath when lying flat | O Yes | O No | Chest pain | O Yes | O No |
| Irregular heartbeat or palpitations | O Yes | O No | Ankle swelling | O Yes | O No |
| **Breast (women)** | | | | | |
| Breast pain | O Yes | O No | Breast lump | O Yes | O No |
| Nipple discharge | O Yes | O No | Enlarged lymph nodes | O Yes | O No |
| **Gastrointestinal** | | | | | |
| Heartburn / indigestion | O Yes | O No | Abdominal pain | O Yes | O No |
| Nausea | O Yes | O No | Blood in stool | O Yes | O No |
| **Urinary** | | | | | |
| Urinary infection | O Yes | O No | Blood in urine | O Yes | O No |
| **Hematology (Blood)** | | | | | |
| Easy bruising | O Yes | O No | Prolonged bleeding | O Yes | O No |

Name: _____ Date: ____/_____/_____

## Medical History

**Please indicate if you have ever been diagnosed with or treated for any of the following conditions.**

| | Yes | | Yes |
|---|---|---|---|
| Asthma | O | Sleep apnea | O |
| Bronchitis | O | Kidney disease | O |
| Hyperthyroidism | O | Autoimmune disorder | O |
| Hypothyroidism | O | HIV/AIDS | O |
| Thrombosis / Blood Clots | O | Hepatitis B or C | O |
| Varicose veins | O | Mitral valve prolapse | O |
| Diabetes | O | Atrial fibrillation | O |
| Heart murmur | O | Congestive heart failure | O |
| Hypertension / high blood pressure | O | Stroke | O |
| Coronary artery disease / angina | O | Multiple sclerosis | O |
| Abnormal uterine bleeding | O | Alcohol abuse | O |
| Neurologic disorder | O | Drug abuse | O |
| Anxiety disorder / panic attacks | O | Depression / bipolar disorder | O |

Other diagnosed conditions: _____

## Family Medical History

Anyone in your family have any of following conditions?_____

O Cardiac problems

O Malignant hyperthermia

## *Ob Gyn History (Women)*

Have you had any pregnancies? O Yes O No If yes, how many? _____ How many live births? _____

## *Anesthesia History*

Have you had any problems with anesthesia in the past? O Yes O No

If yes, what? O severe nausea/vomiting O other:_____