Santa Barbara Plastic Surgery Center

WESLEY G. SCHOOLER, M.D., F.A.C.S.

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

Name: _____ _____ Date: ____/_____/_____

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

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

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Other diagnosed conditions: _____

Name: _____ _____ Date: ____/_____/_____

Family Medical History

Family Medical History

Anyone in your family have any of following conditions? _____ _____ _____ O Cardiac problems	O Respiratory problems	Anyone in your family have any of following conditions? _____ _____ _____ O Cardiac problems	O Respiratory problems .....
O Malignant hyperthermia	O Problems with anesthesia	O Malignant hyperthermia	O Problems with anesthesia .....

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:_____