AESTHETIC CENTER OF PLASTIC SURGERY

888-747-0177

115 West Century Ave. Suite B Bismarck, ND 58503

Patient: **Date:**			
DOB	Age	Marital Status	Weight lbs
Reason for today's visit:			Height ft in

DO YOU NOW OR HAVE YOU EVER HAD…….. (You must circle an answer for each individual item)

Heart Trouble	Yes	No	Glaucoma or Eye Problems	Yes	No
Heart Attack	Yes	No	Hepatitis	Yes	No
Stroke	Yes	No	Yellow Jaundice	Yes	No
Hypertension	Yes	No	Gallstones or Gallbladder Trouble	Yes	No
Rheumatic Fever	Yes	No	Alcoholism or Drug Dependency	Yes	No
Chronic Cough	Yes	No	Frequent Indigestion	Yes	No
Shortness of Breath	Yes	No	Ulcers	Yes	No
Chest Pain	Yes	No	Gastritis	Yes	No
Asthma	Yes	No	Colitis	Yes	No
Bronchitis	Yes	No	Problem Constipation	Yes	No
Pneumonia	Yes	No	Vomiting Blood	Yes	No
Tuberculosis	Yes	No	Goiter or Thyroid Disorders	Yes	No
Major Allergies	Yes	No	Diabetes	Yes	No
Palsy or Paralysis	Yes	No	Skin Disorders	Yes	No
Nervous Disorder	Yes	No	Arthritis	Yes	No
Drug Habit	Yes	No	Fracture of Neck or Spine	Yes	No
Self-Destructive Tendencies	Yes	No	Bleeding Tendency or Disorder	Yes	No
Psychiatric Hospitalization or Care	Yes	No	Abnormal Bleeding after Tooth Extraction	Yes	No
Thyroid Problems	Yes	No	Airway Obstruction (Nasal)	Yes	No
Kidney or Renal Disease	Yes	No	Breast Cysts, Tumors, Abscesses	Yes	No
Heart murmur	Yes	No	Nipple Discharge (Apart from Normal Lactation)	Yes	No
Piercing other than the ears	Yes	No	Kidney Disorder	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No	Blood Transfusion	Yes	No
Family history of cancer, heart trouble, stroke	Yes	No	Seizures or convulsions or fainting spells	Yes	No
Dentures, bridges, capped teeth or crowns	Yes	No	Any family members with bleeding problems	Yes	No
			Any family members with anesthesia problems	Yes	No

1. Have you ever seen another physician pertaining to reasons for todays visit?_____
2. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

   _____

   _____
3. Do you have an allergic reaction to any medication? ❒ Yes ❒ No Which? _____
4. Have you ever had any difficulties with any anesthesia? ❒ Yes ❒ No If yes, when and where? _____
5. Do consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol? ❒ Yes ❒ No Amount:_____
   Do you smoke? ❒ Yes ❒ No Amount: _____
6. Are you pregnant? ❒ Yes ❒ No When was you last normal menstrual period? _____
7. How many pregnancies? _____ Births? _____ Breast Fed? ❒ Yes ❒ No How long? _____
8. Who is your Primary Care Doctor: _____
9. Have you ever been under psychiatric care? ❒ Yes ❒ No When? _____Why? _____
10. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:

    _____

    _____

By signing below, I agreee that the above information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____