

Reason for visit _____ Date _____

Age _____ Race _____ Sex _____ Height _____ Weight _____

Medical History:

Do you have any **medical conditions** in the following Areas? If Yes, please explain

- | | | |
|--------------------------|--------------------------|---------------------------------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Disorders _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Pressure(high) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Clot (leg or lung) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Breathing Problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Circulation Problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold Sores/Herpes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating Disorders _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye Problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal Problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hormonal Changes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacements _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraines _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Antibiotic for MVP _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Please list your current **medications** (include over the counter):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Do you have any **allergies** to medications?

No Yes (Please list):

1. _____
2. _____
3. _____

Women:

Mammogram Yes No Date: _____

Are you pregnant at this time? Yes No

Are you currently breast feeding Yes No

When was your last menstrual period? _____

Number of pregnancies: _____

Number of children _____ Caesarean section _____

Breast Enhancement Patients Only:

Current bra size _____ Desired bra size _____

Family History:

Breast Cancer Yes No

If yes, Mother ___ Aunt ___ Grandmother ___

Other: _____

Skin Disease/Cancer? Yes No

If yes, relationship _____

Social History:

Do you smoke? Yes No

How much _____ How long _____

Do you drink alcohol? Yes No

Occasional Never

History of alcoholism? Yes No

Do you ever use illicit drugs? Yes No

Referred by:

Cleveland Magazine

Friend

Internet

Phone Book

Physician _____

Other _____

Please list all prior **surgeries** that you have had:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Problems with anesthesia? Yes No

Explain: _____

Patient Name: _____

Reviewed by: _____