

MONA LISA COSMETIC SURGERY CENTER

Health History Questionnaire

Name: _____ Age _____ Ht _____ Wt _____

Are you in good health? _____ Are you under the care of a physician? Yes/No _____ If So Whom? _____

Physician's Phone _____

When was your last physical exam? _____ Was everything O.K? Yes/ No _____

Please List Any Drug Other Allergies:

Please List All Medications You Are Currently Taking (Include Any Over the Counter Medications):

Please List Any Current or Past Medical Illness with Dates:

Please List All Hospitalizations, Injuries or Accidents with Dates:

Please List Any Surgeries (Including Cosmetic) with Dates:

Any Significant Hereditary Disorders (Excessive Bleeding):

Do You Smoke? Yes No If Yes, What Type ?

Do You Drink Alcohol? None Occasionally Moderately Excessively

Have You Ever Had A Bad Surgical Result? Explain

If Female: Are You Pregnant Or Planning A Pregnancy? Yes No

Do You Have Any Problems With: Breathing through Your Nose, Chronic Nose Or Sinus Complaints? Yes No If Yes, Please Explain:

List Below Any Other Fact Of A Medical Or Other Nature Which You Feel You Should Make Known Before You Undergo Surgery:

For Physician Use:

Additional Actions To Be Taken Prior To Surgery

Medical Clearance Required Prior to Surgery

() Cardiologist () Internist Patient's Personal Physician Psychiatrist Psychologist EKG Electrolytes SMAC Panel Other

Additional Medications Prior to Surgery Other

I Have Reviewed the Health History Questionnaire with the Patient.

SIGNATURE _____