MONA LISA COSMETIC SURGERY CENTER
Health History Questionnaire

Print this page

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 _____