Please answer the following questions

Print this page

Do you have herpes or cold sore breakouts? ..... Yes No
Do you have frequent headaches? ..... Yes No
Do you have asthma or any chronic lung or bronchial condition? ..... Yes No
Do you experience recurrent chest pains or shortness of breath? .....Yes No
Have you ever been told you have any trouble with your heart? .....Yes No
Do you have any abdominal problems: ..... . Yes No
(stomach, intestinal, gallbladder, liver, hernia, hepatitis)?
Do you test positive for hepatitis or have you had acute or chronic hepatitis ? ..... .Yes No
Any trouble with your kidneys, bladder or reproductive system? ..... .Yes No
Any bone joint or muscular trouble? ..... Yes No
Do you have any chronic skin conditions? ..... Yes No
Do you have any of the following: diabetes, epilepsy or high blood pressure? .....Yes No
Do you have AIDS or are you positive for the AIDS virus? .....Yes No
Have you ever had a nervous breakdown? ..... Yes No
Have you ever been under the care of a psychiatrist or psychologist? .....Yes No
Have you had any marked loss or gain of weight lately? ..... Yes No
Are you on a special diet at the present time or taking Phen-Fen or Redux ? .....Yes No
Do you bleed or bruise easily? ..... Yes No
Do your cuts seem to bleed longer than other people? ..... Yes No
Do the blood vessels in your skin sometimes break without apparent cause? .....Yes No
Have you ever broken your nose? ..... Yes No
Do you have difficulty breathing through your nose? ..... Yes No
Do you have nose bleeds? ..... Yes No
Have you ever had any bleeding requiring the attention of a doctor? ..... Yes No
Have you ever had a blood transfusion? ..... Yes No
Have you ever had excessive bleeding following surgery or dental work? ..... Yes No
(FOR WOMEN) Do your periods last longer than 4 or 5 days? ..... Yes No
Have you ever had poor scarring or keloid formation following an operation or
vaccination? ..... Yes No
Did you have a normal recovery following a prior surgery? ..... Yes No
Are you extremely sensitive to anesthetics or any medicines? ..... Yes No
Do you understand that no surgeon can **guarantee** a good result in any
operation that is performed? ..... Yes No
Do you understand that anyone undergoing any operation, no matter how
minor, must assume a certain risk? ..... Yes No
Have you ever been dissatisfied with the treatment you received from a doctor? ..... Yes No
If yes, please explain:-

Are you taking any of the following frequently, regularly or once in a while? **Comments**

Allergy shots	Yes No	Antibiotics	Yes No
Antidepressants	Yes No	Antihistamines	Yes No
Arthritis medicine	Yes No	Aspirin	Yes No
Sleeping pills	Yes No	Birth Control pills	Yes No
Blood thinners	Yes No	Blood pressure meds.	Yes No
Cortisone	Yes No	Diabetes medicine	Yes No
Diet pills	Yes No	Diuretics (fluid pills)	Yes No
Eye medicine	Yes No	Headache medicine	Yes No
Heart medicine	Yes No	Hormones	Yes No
Iron	Yes No	Laxatives	Yes No
Nose drops	Yes No	Pain relievers	Yes No
Thyroid medicine	Yes No	Stomach medicine	Yes No
Vitamins	YesNo	Tranquilizers	Yes No

List all medicines and dosages taken within the past two weeks:

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the above have been answered will not hold my surgeon, or any of her/his staff responsible for any errors or omissions that I have made in completing this Health History Questionaire.

Signature _____ Date _____