Aesthetic Arts Institute of Plastic Surgery

8415 Grant Avenue, La Mesa CA 91941

MEDICAL HISTORY INFORMATION

PATIENT NAME: ____

AGE: ______________________ HEIGHT: ______________________ WEIGHT: ________________

PAST MEDICAL HISTORY:

HEART ATTACK	___YES ___NO	BULIMIA OR ANOREXIA	___YES ___NO
CONGESTIVE HEART FAILURE	___YES ___NO	CHRONIC ILLNESS	___YES ___NO
AUTOIMMUNE DISORDER	___YES ___NO	ANXIETY DISORDER	___YES ___NO
ASTHMA	___YES ___NO	BIPOLAR DISORDER	___YES ___NO
DRUG DEPENDENCY	___YES ___NO	DEPRESSION	___YES ___NO
BLOOD CLOTTING DISORDER	___YES ___NO	ANEMIA	___YES ___NO
LUNG DISEASE	___YES ___NO	HIGH BLOOD PRESSURE	___YES ___NO
BLOOD DISORDER	___YES ___NO	CANCER	___YES ___NO
SERIOUS ACCIDENT	___YES ___NO	DIABETES	___YES ___NO
SLEEP APNEA	___YES ___NO	CPAP MACHINE	___YES ___NO
LATEX ALLERGIES	___YES ___NO	ENVIRONMENTAL ALLERGIES	___YES ___NO
ACID REFLUX	___YES ___NO	BIRTH CONTROL	___YES ___NO
HEPATITIS	___YES ___NO	HIV	___YES ___NO
STROK	___YES___NO	PACEMAKER	___YES___NO

MEDICINE ALLERGIES: ____

____

____

LIST ALL MEDICATIONS AND HERBAL SUPPLEMENTS: ______________________________

____

____

LIST ALL PREVIOUS SURGERIES:

______________________________ DATE: ____________ COMPLICATIONS: ______________

______________________________ DATE: ____________ COMPLICATIONS: ______________

______________________________ DATE: ____________ COMPLICATIONS: ______________

______________________________ DATE: ____________ COMPLICATIONS: ______________

CHILDBIRTH:

IS THERE ANY CHANCE YOU ARE OR COULD BE PREGNANT NOW? YES NO # OF PREGNANCIES____ # OF CHILDREN ____

LIFESTYLE:

DO YOU SMOKE? YES NO PACKS PER DAY: ________ NUMBER OF YEARS: ________ WHEN DID YOU QUIT? ________

HOW MANY DRINKS CONTAINING ALCOHOL DO YOU DRINK IN A WEEK? ____________

DO YOU TAKE ASPIRIN OR IBUPROFEN ON A REGULAR BASIS? YES NO

ARE YOU ON A DIET PILL OR DIET PROGRAM? YES NO HAVE YOU BEEN IN THE PAST 3 YEARS? YES NO

DO YOU EXERCISE? YES NO ACTIVITY:____

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PATIENT QUESTIONNAIRE

NAME: ______________________________ DATE: ______________

WHAT PROCEDURE(S) ARE YOU INTERESTED IN? ______________________________

HOW LONG HAVE YOU BEEN THINKING ABOUT THIS? ______________________________

HAS ANYTHING HAPPENED RECENTLY TO STIMULATE YOUR INTEREST IN HAVING THIS DONE AT THIS TIME? ______________
____

WHAT DO YOU EXPECT THIS SURGERY/PROCEDURE TO DO FOR YOU? ______________________________
____

DO YOU HAVE ANY CONCERNS ABOUT HAVING THIS SURGERY/PROCEDURE? ______________________________
____

WHEN ARE YOU THINKING OF HAVING THIS PROCEDURE DONE? ☐ ASAP ☐ 1-8 WEEKS ☐ 2-6 MONTHS ☐ 6-12 MONTHS

HAVE YOU DISCUSSED THIS WITH YOUR SPOUSE, FAMILY, AND/OR FRIENDS? YES NO ☐ SPOUSE ☐ FAMILY ☐ FRIENDS

WHAT WAS THEIR OPINION? ☐ VERY SUPPORTIVE ☐ SUPPORTIVE ☐ UNCOMMITTED

☐ AGAINST IT ☐ VERY MUCH AGAINST IT ☐ OTHER: ______________

OTHER FAMILY/FRIENDS COMMENTS: ______________________________

HAVE YOU VISITED OUR WEBSITE? YES NO DID OUR WEBSITE INFLUENCE YOUR DECISION TO SEE US? YES NO

HAVE YOU EVER HAD ANY OTHER COSMETIC SURGERY/PROCEDURE(S)? YES NO

WHAT TYPE? ______________ DOCTOR: ______________ DATE: ______________

WHAT QUALITIES DO YOU CONSIDER MOST IMPORTANT IN YOUR CHOICE OF THE DOCTOR, STAFF, AND FACILITY TO DO YOUR SURGERY/PROCEDURE?

☐ QUALITY ☐ TRUST ☐ CONFIDENCE ☐ SUPERIOR FACILITIES

☐ SAFETY ☐ EXPERIENCE ☐ REPUTATION ☐ RESULTS

☐ FINANCING ☐ CONVENIENCE ☐ GUIDANCE ☐ PRICE

☐ BOARD CERTIFICATION