ALEXANDER Q. ERESO, MD, FACS

Plastic and Reconstructive Surgery

Patient Health History Form

Patient Name: _____ Age:_____ DOB_____

How did you find us/Who referred you?: _____

Reason for Consultation:_____

Past Medical History

a. Major illness/Injury:_____

_____

b. Past Hospitalizations/Surgical History: [ ] No [ ] Yes (Have you had any prior surgery/surgeries? If Yes please provide Date, Type of Surgery & if any complications): _____

_____

_____

Previous Treatments (provide dates, duration, and if the treatment helped)

Botox: _____

Dermal Fillers: _____

Lasers/Peels/Facials: _____

Have you ever had problems with anesthesia? [ ] No [ ] Yes

Allergies (medication or environmental, include reaction)

_____

_____

Family History

Do you have a family history of trouble with anesthesia? [ ] No [ ] Yes

Do you have a family history of easy bleeding or clotting? [ ] No [ ] Yes

Social History

Do you smoke? [ ] Yes. _____ packs of cigarettes per day for ____ years. (includes vaping, chewing, nicotine replacement)

[ ] No, I've never smoked [ ] No. I quit __years ago. I was smoking ___ packs/day for ___ years.

Do you drink alcohol? [ ] No, never (or rarely) [ ] No, but I used to [ ] Yes, How often? _____

Do drugs? [ ] Yes. _____(name of drug) for _____ (duration and frequency)

[ ] No, I have never done drugs.

[ ] No, I quit __ years ago. Before, I used: _____ (drug) for __ years.

Occupation: _____

List of current medications (including Aspirin, steroids, vitamins and herbal medications/teas, birth control):

_____

_____

REVIEW OF SYSTEMS: Are you currently, or have you had, problems with:

CONSTITUTIONAL	**Circle One**	
Weight Gain	YES	NO
Weight Loss	YES	NO
Night Sweats	YES	NO
Insomnia	YES	NO
EYES		
Double vision	YES	NO
Visual Loss	YES	NO
EAR, NOSE THROAT AND MOUTH		
Hearing Loss	YES	NO
Noise/Ringing in ears	YES	NO
Nasal Congestion	YES	NO
Nasal Drainage	YES	NO
Sore Throat	YES	NO
Trouble Swallowing	YES	NO
Hoarseness	YES	NO
Cold Sores	YES	NO
CARDIOVASCULAR		
Chest Pain or Angina	YES	NO
Heart Trouble	YES	NO
Rheumatic Fever	YES	NO
Heart Murmur	YES	NO
High Blood Pressure	YES	NO
NEUROLOGICAL		
Numbness	YES	NO
Weakness	YES	NO
Stroke	YES	NO
Headache	YES	NO
PSYCHIATRIC		
Depression	YES	NO
Any other treatment (list)_____	YES	NO
ALLERGIC/IMMUNOLOGIC		
Sneezing	YES	NO
Itchy Eye/Nose	YES	NO
Itchy Throat	YES	NO
Skin Rash	YES	NO
HIV	YES	NO
MUSCULOSKELETAL		
Arthritis	YES	NO

RESPIRATORY	**Circle One**	
Asthma	YES	NO
Cough up Blood	YES	NO
TB	YES	NO
Pneumonia	YES	NO
Snoring	YES	NO
Sleep Apnea	YES	NO
GASTROINTESTINAL		
Indigestion or Heartburn	YES	NO
Hepatitis	YES	NO
Jaundice	YES	NO
Blood in Stool	YES	NO
Black, Tarry Stools	YES	NO
GENITOURINARY		
Bladder Trouble	YES	NO
Kidney Disease	YES	NO
ENDOCRINE		
Diabetes	YES	NO
Thyroid Disease	YES	NO
HEMATOLOGIC		
Bleeding Disorder	YES	NO
Easy Bleeding	YES	NO

OTHER

Would you accept a blood transfusion if there is a life-threatening emergency? YES NO

Do you have any other disease or problem not listed here? If yes, please list below YES NO

_____

_____

Height _____ **Weight** _____

The above information is accurate to the best of my knowledge.

_____ _____

Patient Signature Date

I have reviewed the above information with the patient.

_____

Alexander Q. Ereso, MD, FACS