Paige C. Holt MD • Glori Traeder CNP

Plastic Surgery & Aesthetics

Personal Information

Date: _____ Name: _____

Date of Birth: _____ Age: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Work Phone: (____) ____ - _____ Cell Phone: (____) ____ - _____

Email address: _____

Emergency Contact Name and Phone: _____ Relationship _____

How did you hear about us? _____

What is the nature of your visit? _____

Medical History

Height: _____ Weight: _____ Primary care provider: _____

Are you allergic to any medication, latex or local anesthesia? No Yes, please list with reaction:

_____

_____

Have you or do you still have: (Please check all that apply.)

□ Cancer □ Asthma □ Skin Disease / Skin Lesions □ High Blood Pressure
□ HIV/AIDS Heart trouble Neurologic Disease □ Pacemaker/Defibrillator
Stroke □ Seizure Disorder □ Frequent Cold Sores □ Any Active Infection
□ Diabetes □ Arthritis Hormone Imbalance Thyroid Imbalance
Hepatitis □ Herpes Keloid Scarring □ Problem Scarring □ Blood Clotting Abnormalities
Others Not Listed: _____

Have you ever had surgery? No Yes, please describe:

_____

_____

Do you have a blood relative who had anesthesia complications of any kind? No Yes, please describe:

_____

_____

Social History

Do you smoke? □ No □ Yes, how much? _____

Previous smoking history? □ No □ Yes, how long ago? _____

Do you drink? □ No □ Yes, how much? _____

Do you regularly sun bathe or use tanning salons? _____ How Often? _____

Sun Exposure History: _____

Medications

Are you taking any medications, vitamins or herbal supplements? No Yes, please list with dose and frequency:

_____
_____
_____
_____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No:

Constitutional symptoms:
- Fever Y N
- Chills Y N
- Headache Y N
- Other _____

Ears, Nose, Throat:
- Hearing Loss Y N
- Sneezing Y N
- Congestion Y N
- Other _____

Cardiovascular:
- Chest Pain Y N
- Shortness of Breath Y N
- Cough Y N
- Other _____

Neurological:
- Dizziness Y N
- Numbness/Tingling in Arms or Legs Y N
- Frequent Headaches Y N
- Other _____

Lymphatics:
- Enlarged Lymph Nodes Y N
- Other _____

Psychiatric:
- Depression Y N
- Anxiety Y N
- Other _____

Gastrointestinal:
- Anorexia Y N
- Nausea/Vomiting Y N
- Abdominal Pain Y N
- Other _____

Eyes:
- Blurred Vision Y N
- Visual Loss Y N
- Double Vision Y N
- Other_____

Skin:
- Itchy skin Y N
- Rash Y N
- Hives Y N
- Other _____

Hematologic:
- Anemia Y N
- Bruising Y N
- Bleeding Y N
- Other _____

Genitourinary:
- Painful Urination Y N
- Urination Incontinence Y N
- Other _____

Musculoskeletal:
- Muscle Pain Y N
- Back Pain Y N
- Joint Pain Y N
- Other _____

Endocrine:
- Night Sweats Y N
- Hot/Cold Intolerance Y N
- Other _____

Family History

Have any blood relatives had any pertinent medical history including:

Cancer No Yes Describe: _____

Bleeding Tendency No Yes Describe: _____

Leukemia No Yes Describe: _____

Heart Disease No Yes Describe: _____

High Blood Pressure No Yes Describe: _____

Repeated Infections No Yes Describe: _____

Chronic Lung Disease No Yes Describe: _____

Family History Continued…

Tuberculosis No Yes Describe: _____

Asthma No Yes Describe: _____

Severe Allergies No Yes Describe: _____

Kidney Disease No Yes Describe: _____

Arthritis No Yes Describe: _____

Mental Illness No Yes Describe: _____

Convulsions No Yes Describe: _____

Migraine Headaches No Yes Describe: _____

Diabetes No Yes Describe: _____

Gout No Yes Describe: _____

Thyroid Trouble No Yes Describe: _____

Heart Surgery No Yes Describe: _____

Obesity No Yes Describe: _____

For Female Clients:

Are you pregnant or trying to become pregnant? □ No □ Yes

Are you breastfeeding? □ No □ Yes

Are you using contraception? □ No □ Yes

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: _____ Date: _____