Aestique® Plastic Surgery & MediSpa
Medical History

Patient Name: _____ D.O.B: _____ Age: _____

Stated Height: _____ Stated Weight: _____ Blood Pressure: _____

Referring Physician (Address & Phone): _____

Primary Care Physician (Address & Phone): _____

How did you hear about us? _____

Past Medical History: (Please circle yes or no – ***MUST BE WITHIN LAST YEAR***.)

Neurological:	Migraine/ Headache	Yes	No
	Glaucoma	Yes	No
Pulmonary:	Asthma	Yes	No
	Deep Vein Thrombosis	Yes	No
	Sleep Apnea	Yes	No
	Lung Cancer/TB	Yes	No
	Emphysema / COPD	Yes	No
	Pulmonary Embolism	Yes	No
Cardiac:	High Blood Pressure	Yes	No
	Heart Attack	Yes	No
	Heart Surgery	Yes	No
	Coronary Artery Disease	Yes	No
	Irregular Heart Beat	Yes	No
	Atrial Fibrillation	Yes	No
Gastrointestinal:	Reflux / Heartburn	Yes	No
	Hiatal Hernia	Yes	No
Liver:	Liver Disease / Cirrhosis	Yes	No
	Hepatitis	Yes	No
Gyn/Breast:	Breast Cancer/ Mastectomy	Yes	No
	Are you pregnant?	Yes	No
	Are you breast feeding?	Yes	No
	Number of pregnancies:		
	Number of births:		
	Last Mammogram:		
Skin:	Cancer	Yes	No
	Eczema	Yes	No
	Psoriosis	Yes	No
	Cold Sores	Yes	No
Hair	Hair thinning	Yes	No

Endocrine:	Diabetes	Yes	No
	Hypoglycemia	Yes	No
	Thyroid Disease	Yes	No
Renal/Genitourinary	Kidney Disease	Yes	No
	Kidney Failure	Yes	No
Vascular:	Aneurysm	Yes	No
	Poor Circulation	Yes	No
Rheumatology	Rheumatoid Arthritis	Yes	No
	Osteoarthritis	Yes	No
	Lupus / Scleroderma	Yes	No
	Fibromyalgia	Yes	No
Hematology / Infectious Disease:	Anemia	Yes	No
	Bleeding Tendencies	Yes	No
	Hemophilia	Yes	No
	Sickle Cell	Yes	No
	Low Platelets	Yes	No
	Thrombocytopenia	Yes	No
	Sexually Transmitted Disease	Yes	No
	HIV / AIDS	Yes	No
Musculoskeletal:	Artificial joint / prosthesis	Yes	No
	Multiple Sclerosis	Yes	No
Cancer/ Malignancy:	Location:		
	Chemotherapy	Yes	No
	Radiation	Yes	No
	Date finished tx:		
Psychiatric:	Depression / Anxiety	Yes	No
	ADHD / Bi-Polar	Yes	No
	Eating Disorder	Yes	No
	Schizophrenia	Yes	No

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Past Surgical History: **(**Please list name of procedure and date.)

1._____ 2._____

3._____ 4._____

5._____ 6._____

Medications: (Please list all current medications and dosages.)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Drug Allergies: YES / NO **List**:_____

Reactions:_____

Do you have an allergy to Latex? YES NO
Do you have an allergy to Codeine? YES NO
Have you ever been on Accutane? YES NO
If yes, when: _____

Social History:

1. Occupation: _____
2. Single/Married/Separated/Divorced (circle one)
3. Have you ever used tobacco?: Yes No
   If yes, # of packs per day?:_____ for # of years?:_____
   If you quit using tobacco, when?:_____
4. Do you drink alcohol?: Yes No
   How much: _____ How often?:_____
5. Do you use recreational drugs?: Yes No
   Type:_____

Family History: Please list any family medical history/problems.

	Age	Diseases	Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____

ACKNOWLEDGEMENT:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Aestique Plastic Surgical Associates of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Patient Signature:_____ **Date:**_____

Revised: 10/28/20