Perfecting your natural beauty

Gallas
plastic surgery & vein center

PATIENT HEALTH HISTORY

PATIENT NAME:_____ **AGE**:_____

Please answer all of the questions as accurately as possible. If you do not understand the question, please ask for assistance.

Primary Care Doctor:_____
Smoking (type & amount per day)_____ Alcohol (type & amount per week)_____
If former smoker, date quit:_____ Weight_____ Height_____

Drug allergies and reactions:_____
_____

List previous surgeries or major illnesses and dates:_____
_____

List any medications you are taking, including non-prescription, vitamins and herbals:_____
_____
_____

Family History:

Has any blood relative ever had the following? (check all that apply):

Breast Cancer		High Blood Pressure		Kidney Disease		Stroke	
Melanoma		Heart Disease		Depression		Diabetes	

Past Medical History:

Have you ever had the following?: (check all that apply)

Heart Disease		Cancer		Stomach Ulcer		Arthritis	
Glaucoma		Kidney Disease		Rheumatic Fever		Asthma	
Thyroid Disease		Anemia		AIDS or HIV		Bleeding Tendency	
Tuberculosis		Stroke		Mitral Valve Prolapse		High Blood Pressure	
Diabetes		Hepatitis					

Review of Symptoms:

Do you have or have you had within the past year: (check all that apply)

Weight Changes		Swollen feet/ankles		Seizures		Dry Eyes	
Skin Rash		Joint/Muscle Pain		Chronic Cough		Chronic Diarrhea	
Swollen Lymph Nodes		Chest Pain		Jaundice		Easy Bleeding	
Rapid Heart Beat		Depression		Easy Bruising			

Women Only:

Date of last mammogram_____
Do you do regular breast self-exams? ___Yes___No
Have you had a breast lump or discharge? ___Yes___No
Did you breast feed? ___Yes___No
Bra size_____

Have you had/or plan to have any:
Chemotherapy ____Yes____No
Radiation ____Yes____No
Date of last Treatment _____

I verify that the above information is true and accurate to the best of my knowledge.

X_____ _____
Signature of Patient or Parent if Minor Date

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