somenek+ pittman MD
ADVANCED PLASTIC SURGERY
SURGICAL SUITE

PATIENT LABEL

Health History Questionnaire

Name: _____ **M / F / O** Age:_____ Wt:_____ Ht:_____

Do you wear? *(Circle one)*

Contacts: Y N **Dentures:** Y N **Hearing Aids**: Y N Left/Right/Both

Allergies and Reactions to Medications: _____
(Please list)

Allergies to Foods, Tape, Soap, LATEX, etc._____
(Please list)

Who will take you home? _____ Relationship:_____ Phone#_____

Have you or a blood relative ever had a complication with anesthesia? ☐ Yes ☐ No
Do you take blood thinning medications, including Aspirin or Ibuprofen regularly? ☐ Yes ☐ No
Have you had any issues with bleeding in previous surgeries or dental procedures? ☐ Yes ☐ No
Any issues with excessive snoring or anyone witnessed you quit breathing at night? ☐ Yes ☐ No

If yes to any above, describe_____

Previous Surgeries/dates _____

☐ **I have completed the medication reconciliation form (attached)**

Medical History *(Check all that apply to you)*

Cardiac ☐ Angina/Chest Pain ☐ Congestive Heart Failure ☐ Irreg. Heart Beats ☐ Coronary Bypass #___ ☐ High Blood Pressure ☐ Pacemaker ☐ History of Malignant Hyperthermia	**Lungs** ☐ Asthma/Use Inhalers ☐ Emphysema ☐ COPD/Use Oxygen at home? ☐ Bronchitis ☐ Allergies ☐ Sleep Apnea/Wear CPAP? ☐ Smoker, # Packs per Day	**Thyroid** ☐ Hyperthyroid ☐ Hypothyroid **Eyes** ☐ Glaucoma ☐ Cataract surgery ☐ Retina surgery
Kidney ☐ Chronic Urinary Tract Inf. ☐ Dialysis, When_____ ☐ Voiding at Night #_____	**Liver** ☐ Hepatitis A,B,or C ☐ Cirrhosis	**Diabetics** ☐ Oral Meds ☐ Insulin Reg/NPH ☐ Diet Controlled
Central Nervous System ☐ Stroke/TIA's ☐ Seizures/Migraines **Pregnancy Screen** ☐ Possibility that you might be pregnant? If yes, please speak with your surgeon	**Other** ☐ Alcohol Use How Often_____ ☐ Drug Use Specify_____ ☐ Bleeding Disorders ☐ HIV / AIDS ☐ History of Mental Illness ☐ **Take/Have taken FLOMAX**	☐ Muscle/Neuro-Muscular Disorder ☐ High Temp following exercise ☐ History of Muscle Spasms ☐ Dark Colored Urine after exercise

Please complete this form and return it to our office before surgery or bring it with you the day of surgery.

Patient/Guardian Signature:_____ **Date:**_____