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)*

<table>
<tr>
<td>Cardiac
☐ Angina/Chest Pain
☐ Congestive Heart Failure
☐ Irreg. Heart Beats
☐ Coronary Bypass #___
☐ High Blood Pressure
☐ Pacemaker
☐ History of Malignant Hyperthermia</td>
<td>Lungs
☐ Asthma/Use Inhalers
☐ Emphysema
☐ COPD/Use Oxygen at home?
☐ Bronchitis
☐ Allergies
☐ Sleep Apnea/Wear CPAP?
☐ Smoker, # Packs per Day</td>
<td>Thyroid
☐ Hyperthyroid
☐ Hypothyroid

Eyes
☐ Glaucoma ☐ Cataract surgery
☐ Retina surgery</td>
</tr>
<tr>
<td>Kidney
☐ Chronic Urinary Tract Inf.
☐ Dialysis, When_____
☐ Voiding at Night #_____</td>
<td>Liver
☐ Hepatitis A,B,or C
☐ Cirrhosis</td>
<td>Diabetics
☐ Oral Meds
☐ Insulin Reg/NPH
☐ Diet Controlled</td>
</tr>
<tr>
<td>Central Nervous System
☐ Stroke/TIA’s
☐ Seizures/Migraines

Pregnancy Screen
☐ Possibility that you might be pregnant? If yes, please speak with your surgeon</td>
<td colspan="2">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</td>
</tr>
</table>

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:**_____