

*Welcome to the Emory Aesthetic Center! Please help us take the best care for you by providing us with the following important health information. Thank you!*



REASON FOR VISIT/AREA OF INTEREST: \_\_\_\_\_

Do you or a family member work for Emory Healthcare/Emory University?  YES  NO

Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_ Age \_\_\_\_\_

DRUG ALLERGIES? Please specify: \_\_\_\_\_  NO KNOWN DRUG ALLERGIES

FOOD ALLERGIES? Please specify: \_\_\_\_\_  NO KNOWN FOOD ALLERGIES

LATEX ALLERGY?  YES  NO ADHESIVE TAPE ALLERGY?  YES  NO

PRIMARY CARE PHYSICIAN \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

PRIOR SURGERY Procedure \_\_\_\_\_ Year \_\_\_\_\_ Surgeon/Location \_\_\_\_\_  
 Procedure \_\_\_\_\_ Year \_\_\_\_\_ Surgeon/Location \_\_\_\_\_  
 Procedure \_\_\_\_\_ Year \_\_\_\_\_ Surgeon/Location \_\_\_\_\_  
 Procedure \_\_\_\_\_ Year \_\_\_\_\_ Surgeon/Location \_\_\_\_\_

**FOR WOMEN**

YES  NO Personal or family history of breast cancer Bra size \_\_\_\_\_

YES  NO Breast mass  YES  NO Nipple discharge  YES  NO Breast pain

YES  NO Are you or could you be pregnant? Have you ever had a mammogram?  YES  NO Date of most recent \_\_\_\_\_  YES  NO

PREGNANCIES Year \_\_\_\_\_  Vaginal Delivery  C-section Year \_\_\_\_\_  Vaginal Delivery  C-section

Year \_\_\_\_\_  Vaginal Delivery  C-section Year \_\_\_\_\_  Vaginal Delivery  C-section

MEDICATIONS: PHARMACY: \_\_\_\_\_ PHARMACY PHONE: \_\_\_\_\_

PRESCRIPTION: Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Medication: \_\_\_\_\_ Dose \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Medication: \_\_\_\_\_ Dose \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Medication: \_\_\_\_\_ Dose \_\_\_\_\_

**OVER THE COUNTER MEDICATIONS:**

Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Medication: \_\_\_\_\_ Dose \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Medication: \_\_\_\_\_ Dose \_\_\_\_\_

**HERBAL/DIETARY SUPPLEMENTS:**

Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Medication: \_\_\_\_\_ Dose \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Medication: \_\_\_\_\_ Dose \_\_\_\_\_

**MEDICAL HISTORY - DO YOU HAVE OR HAVE YOU EVER HAD:**

- YES  NO Heart disease (including: heart murmur, pacemaker, catheterization, stents, surgery, mitral valve prolapsed) Specify: \_\_\_\_\_
- YES  NO Chest pain Do you exercise regularly? YES \_\_\_ NO \_\_\_ What type \_\_\_\_\_
- YES  NO Previous EKG/stress test/echocardiogram Date(s) \_\_\_\_\_
- YES  NO High blood pressure
- YES  NO Asthma Hospitalizations  YES  NO how many \_\_\_\_\_
- YES  NO Lung disease Specify \_\_\_\_\_
- YES  NO Chronic cough
- YES  NO Shortness of breath
- YES  NO Sleep apnea
- YES  NO CPAP machine If YES, do you use it nightly?  YES  NO
- YES  NO Abnormal chest x-ray
- YES  NO Kidney disease Specify \_\_\_\_\_
- YES  NO Difficulty voiding
- YES  NO Liver disease/hepatitis/jaundice Specify \_\_\_\_\_
- YES  NO Diabetes Since \_\_\_\_\_ Do you take insulin?  YES  NO Last Hemaglobin A1C level \_\_\_\_\_
- YES  NO Are you on a special diet? Specify \_\_\_\_\_

- YES  NO Recent weight loss? If yes, was it purposeful?  YES  NO How much weight loss? \_\_\_\_\_  
 YES  NO Anemia \_\_\_\_\_  
 YES  NO Epilepsy/Seizures/Stroke/Neurological problems Specify \_\_\_\_\_  
 YES  NO Autoimmune disorders/connective tissue disorders/lupus/sarcoid Specify \_\_\_\_\_  
 YES  NO Psychological conditions (depression/anxiety, bipolar, schizophrenia, etc.) Specify \_\_\_\_\_  
 YES  NO Thyroid or goiter problems Specify \_\_\_\_\_  
 YES  NO Bowel/colon disease or problems Specify \_\_\_\_\_  
 YES  NO Frequent heartburn/indigestion, esophageal reflux, hiatal hernia \_\_\_\_\_  
 YES  NO Recent vision change \_\_\_\_\_  
 YES  NO Glaucoma \_\_\_\_\_  
 YES  NO Dry eyes \_\_\_\_\_  
 YES  NO Use eye drops \_\_\_\_\_  
 YES  NO Back and/or neck problems Specify \_\_\_\_\_  
 YES  NO Muscle weakness Specify \_\_\_\_\_  
 YES  NO Hepatitis If yes, type (A, B, C)? \_\_\_\_\_ Date diagnosed \_\_\_\_\_  
 YES  NO HIV If yes, date diagnosed \_\_\_\_\_  
 YES  NO MRSA If yes, date diagnosed \_\_\_\_\_  
 YES  NO Past/present carrier of other contagious/infectious disease Specify \_\_\_\_\_  
 YES  NO Metal implants (back,hip,knee,etc.) Specify \_\_\_\_\_  
 YES  NO Exposure to communicable diseases in the past 3 weeks Specify \_\_\_\_\_  
 YES  NO Personal or family history of deep venous thrombosis (DVT, blood clots in legs or lungs) \_\_\_\_\_  
 YES  NO Personal history of bleeding or clotting abnormality (e.g. Factor V Leiden, lupus anticoagulant) \_\_\_\_\_  
 YES  NO Family history of bleeding or clotting abnormality (e.g. Factor V Leiden, lupus anticoagulant) \_\_\_\_\_  
 YES  NO History of blood transfusions Specify \_\_\_\_\_  
 YES  NO Nose surgery \_\_\_\_\_  
 YES  NO Broken bones in face, back, or neck Specify \_\_\_\_\_  
 YES  NO Do you or have you ever smoked? Amount per day \_\_\_\_\_ How many years \_\_\_\_\_ Year quit \_\_\_\_\_  
 YES  NO Use(d) smokeless tobacco How many years \_\_\_\_\_ Year quit \_\_\_\_\_  
 YES  NO Use(d) recreational drugs types(s) \_\_\_\_\_ How much \_\_\_\_\_ How many years \_\_\_\_\_  
 YES  NO Use(d) alcohol type(s) \_\_\_\_\_ How much \_\_\_\_\_  
 YES  NO Been treated for substance abuse type(s) \_\_\_\_\_ When \_\_\_\_\_  
 YES  NO Steroid use in the past 12 months Specify \_\_\_\_\_  
 YES  NO Keloids or unusually large scars \_\_\_\_\_  
 YES  NO Frequent infections or boils \_\_\_\_\_

**ANESTHESIA HISTORY**

- YES  NO Have you ever had a reaction to a regional or local anesthesia injection? If yes, specify \_\_\_\_\_  
 YES  NO Have you ever had a general anesthesia? \_\_\_\_\_  
 YES  NO Have you ever had problems with anesthesia? Specify \_\_\_\_\_  
 YES  NO Have members of your family had problems with anesthesia? Specify \_\_\_\_\_

**DO YOU HAVE OR WEAR ANY OF THE FOLLOWING?**

- |  |                        |  |                 |
|--|------------------------|--|-----------------|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Dentures               | <input type="checkbox"/> YES <input type="checkbox"/> NO | Contact lens    |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Partial plate          | <input type="checkbox"/> YES <input type="checkbox"/> NO | Eye glasses     |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Bridgework - permanent | <input type="checkbox"/> YES <input type="checkbox"/> NO | Wig/hairpiece   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Caps/Crowns            | <input type="checkbox"/> YES <input type="checkbox"/> NO | Hearing aid     |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Chipped/Missing teeth  | <input type="checkbox"/> YES <input type="checkbox"/> NO | False eyelashes |

*I HAVE ANSWERED ALL OF THESE QUESTIONS FULLY AND TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I SHOULD INFORM MY PHYSICIAN IF I EXPERIENCE ANY NEW HEALTH ISSUES OR IF THE STATUS OF MY EXISTING HEALTH ISSUES CHANGES. I AGREE TO HAVE NOTHING BY MOUTH AFTER MIDNIGHT THE NIGHT BEFORE MY SURGERY UNLESS INSTRUCTED TO DO SO.*

\_\_\_\_\_  
 Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Parent,Guardian,next of Kin (if patient unable to sign) Relationship \_\_\_\_\_

(PHYSICIAN ONLY) FORM REVIEWED WITH PATIENT \_\_\_\_\_, M.D. Date \_\_\_\_\_

Updated \_\_\_\_\_ Patient Signature \_\_\_\_\_ Physician Signature \_\_\_\_\_