

# EMORY FACIAL CENTER MEDICAL QUESTIONNAIRE

Name \_\_\_\_\_

Today's date \_\_\_\_\_

Reason for visit today \_\_\_\_\_

**Do you currently have any problems with the following? Please indicate with an X all that apply.**

<b>Heart/Blood Pressure:</b>	High Blood Pressure _____ Low Blood Pressure _____ Heart Attack _____ Heart Murmur _____ Chest Pain/Tightness _____ Irregular Heartbeat _____ Leg Swelling _____	<b>Gastrointestinal:</b>	Ulcers _____ Gastritis _____ Colitis/Diverticulitis _____
<b>Lung:</b>	Bronchitis/Pneumonia _____ Asthma _____ Shortness of Breath _____ Tuberculosis _____	<b>Skin:</b>	Acne _____ Accutane _____ Keloid Scarring _____ Rosacea _____ Cold Sores _____
<b>Ear, Eye, Nose Or Throat:</b>	Dry Eyes _____ Blurred Vision _____ Glaucoma _____ Corrective Lenses _____ Ear Disease _____ Nosebleeds _____ Difficulty Breathing _____ Nasal Allergies _____ Sinus Disease _____	<b>Musculoskeletal/ Neurological:</b>	Convulsions _____ Epilepsy _____ Headaches _____ Arthritis _____
		<b>Hematologic/ Metabolic:</b>	Anemia _____ Bleeding Problems _____ Blood Transfusion _____ HIV/AIDS _____ Autoimmune Disease _____ Diabetes _____ Thyroid Disease _____ Hepatitis _____

**Have you ever been treated for Drug/Alcohol or Psychiatric/ Emotional problems such as Depression, Anxiety?**

Yes No If yes, please explain \_\_\_\_\_

**Have you ever had an anesthesia complication, latex allergy, or surgical tape allergy?**

Yes No If yes, please explain \_\_\_\_\_

**Have you used, within the past 5 years, the following substances? If you have quit, please indicate when.**

Tobacco, any form Yes No How much per day? \_\_\_\_\_

Alcohol Yes No How much per day? \_\_\_\_\_

Recreational Drugs Yes No What and How Often? \_\_\_\_\_

Do you take any Diet Medications? \_\_\_\_\_

**Please turn over for additional questions**

**Surgical History**-Please list all previous surgeries (including Cosmetic)

Operation	Surgeon Name	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Hospitalizations** (Other than for Surgery)

Illness	Physician Name	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Medications, Vitamins and Herbs**

Name of Drug/Vitamin	Strength/Dosage	Condition Treated
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Drug Allergies** (list any reactions to medications, tapes or antiseptic cleansers),  
If no allergies, please mark **NKDA** (no known drug allergies)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_

**If applicable, are you currently in pain?** (0=Pain Free, 10= Most Severe Pain)

\_\_\_\_\_

**Family History** (Please indicate if any immediate family members has ever had any of the following)

Heart Disease \_\_\_\_\_  
Bleeding Disorder \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Anesthetic Complications \_\_\_\_\_  
Cancer \_\_\_\_\_ What type of cancer? \_\_\_\_\_

**Do you have any other medical problems that have not been covered?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by Physician (please initial) \_\_\_\_\_