

EMORY FACIAL CENTER MEDICAL QUESTIONNAIRE

Name _____

Today's date _____

Reason for visit today _____

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

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