EMORY
AESTHETIC CENTER

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!

Reserved for

Patient Sticker

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 Date of most recent _____ ☐ NO

PREGNANCIES Year _____ ☐ Vaginal Delivery ☐ C-section Year _____ ☐ Vaginal Delivery ☐ C-section
Year _____ ☐ Vaginal Delivery ☐ C-section Year _____ ☐ Vaginal Delivery ☐ C-section

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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?

☐ YES	☐ NO	Dentures	☐ YES	☐ NO	Contact lens
☐ YES	☐ NO	Partial plate	☐ YES	☐ NO	Eye glasses
☐ YES	☐ NO	Bridgework – permanent	☐ YES	☐ NO	Wig/hairpiece
☐ YES	☐ NO	Caps/Crowns	☐ YES	☐ NO	Hearing aid
☐ YES	☐ NO	Chipped/Missing teeth	☐ YES	☐ 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 _____