Sullivan Integrated Aesthetic CENTER
Plastic Surgery & Medical Spa

PATIENT MEDICAL HISTORY

CONFIDENTIAL INFORMATION: information contained herein will not be released except when you have authorized us to do so. Please answer **all** questions to the best of your knowledge. The information that you provide will be used by your doctor in decisions regarding your care.

Patient Information

Name:_____ Date of Birth:_____ Age: _____

Physician Information

Referring Physician: _____ Address: _____
Primary Care Physician: _____ Address: _____

Medical Information

Reason for visit:_____
If this is for a medical reason, list date of onset: _____
Height: _____ Weight: _____

Do you currently have, or have you ever had any of the following? (Please circle – if "yes", give date of onset/occurrence)

AIDS or HIV+	No Yes _____	Heart Condition	No Yes _____
Anxiety	No Yes _____	Hepatitis	No Yes _____
Arthritis	No Yes _____	High blood pressure	No Yes _____
Asthma	No Yes _____	Kidney disease	No Yes _____
Back Problems	No Yes _____	Migraines	No Yes _____
Bleeding disorder	No Yes _____	Seizure Disorder	No Yes _____
Blood clotting disorder	No Yes _____	Stomach ulcers	No Yes _____
Cancer	No Yes _____	Stroke	No Yes _____
Colitis	No Yes _____	Thyroid disorder	No Yes _____
Depression	No Yes _____	Tuberculosis	No Yes _____
Diabetes	No Yes _____	Weight loss/gain	No Yes _____
Heart attack	No Yes _____		

Other serious medical conditions that you have or have had, not mentioned above:
_____

Have you ever had surgery? (If "yes", please list the name of the operation and the date it was performed):
_____

Other serious illnesses or injuries that you have had, not mentioned above:
_____

Have you ever had any complications from anesthesia? (If "yes", please explain):
_____

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Social History

Do you currently smoke? Yes No
If "yes": How much? _____ If "no": Have you ever smoked? Yes No If "yes": When did you quit?_____

Do you regularly drink alcohol? Yes No If "yes": How much? _____ How often? _____
Do you have any known allergies to medications, iodine/contrast dye, or LATEX? Yes No
If "yes", please list: _____

For women only:
Is there a chance you might be pregnant? Yes No
Are you still having regular monthly menstrual periods? Yes No Date of last period? _____
Date of last mammogram:_____ Results: _____
How many children do you have? _____
We recommend routine breast and pelvic exams by your physician for all adult females.

Are you presently taking any of the following medications? *(If "yes", please circle and list the name of the medication).*

Accutane (Isotretinoin)	_____	Hormones	_____
Antibiotics	_____	Insulin or diabetic pills	_____
Anxiety/Depression Meds	_____	Laxatives	_____
Arthritis medicine	_____	Retin-A	_____
Aspirin, Bufferin, Anacin	_____	Seizure Meds	_____
Birth control pills	_____	Sleeping pills	_____
Blood pressure pills	_____	Steroids	_____
Blood thinning pills	_____	St. Johns Wart	_____
Cough medicine	_____	Thyroid medicine	_____
Digitalis	_____	Water pills	_____
Headache meds	_____	Weight reducing pills	_____
Herbal Supplement	_____		

Other vitamins, supplements, or medications not listed above: _____
_____

Family Medical History

If a blood relative has/had any of the following conditions, please circle and give relationship (blood relatives includes siblings, parents, grandparents, children):

Bleeding tendency	_____	Heart disease	_____
Blood clotting disorder	_____	Diabetes	_____
Breast cancer	_____	Stroke	_____

Please list anything about yourself or your health that you think would be important for the doctor to know: _____
_____