REVITALIZE
PLASTIC SURGERY & MEDICAL SPA

HEALTH HISTORY FORM

Name: _____ Birth Date: _____ Date of Last Physical Exam: _____ Height: _____ Weight: _____

Reason for consultation: _____ BMI: _____ BSA: _____ SCHN: _____

PAST AND CURRENT MEDICAL CONDITIONS: Check (√) conditions you currently have or have had in the past.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alopecia (hair loss)
- ☐ Anemia (type:_____)
- ☐ Anxiety
- ☐ Appendicitis
- ☐ Arthritis (type:_____)
- ☐ Asthma
- ☐ Back pain
- ☐ Bleeding Disorders
- ☐ Blood Clot (DVT/PE)
- ☐ Bone/Joint Disease
- ☐ Breast Lump
- ☐ Cancer (type:_____)
- ☐ Circulatory Issues
- ☐ Colitis
- ☐ COPD
- ☐ Depression
- ☐ Diabetes (Type: ___, A1c:_____)
- ☐ Dizziness/Fainting
- ☐ Eating Disorder
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fibromyalgia
- ☐ GERD (heartburn)
- ☐ Headache
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis (type:_____)
- ☐ Hernia (type:_____)
- ☐ Herpes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Lipedema
- ☐ Liver Disease or Jaundice
- ☐ Lupus
- ☐ Lymphedema
- ☐ Multiple Sclerosis
- ☐ Narcolepsy
- ☐ Numbness/Tingling
- ☐ Phlebitis
- ☐ Polycystic Ovarian Syndrome
- ☐ Porphyria
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Sinus Issues
- ☐ Skin Lesions
- ☐ Sleep Apnea
- ☐ Spinal Problems
- ☐ STD- Sexual Disease
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Problem
- ☐ Trichotillomania (lash/hair pulling)
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose or Spider Veins
- ☐ Other: _____

OTHER PAST MEDICAL HISTORY: Have you ever had any of the following problems? If yes, please explain.

BLOOD OR LYMPHATIC? ☐ NO ☐ YES, explain: _____
CARDIOVASCULAR? ☐NO ☐ YES, explain: _____
EAR, NOSE OR THROAT (other than cold/flu symptoms)? ☐ NO ☐ YES, explain: _____
EYE DISEASE? ☐ None ☐ Cataracts ☐ Dry eye syndrome ☐ Glaucoma ☐ Retinopathy ☐ Other: _____
GASTROINTESTINAL (ABDOMINAL)? ☐ NO ☐ YES, explain: _____
GENITOURINARY? ☐ NO ☐ YES, explain: _____
EXTERNAL DEVICES? ☐ None ☐ Contact lenses ☐ Hearing aid ☐ Piercings (location: _____)
IMPAIRED IMMUNE SYSTEM (due to a medical condition, chemotherapy, or immunosuppressant medication, etc.)?
☐ NO ☐ YES If yes, explain: _____
IMPLANTABLE DEVICES? ☐ None ☐ Defibrillator ☐ Pacemaker ☐ Hardware (location: _____)
☐ Implant (location: _____)
INFECTIOUS/COMMUNICABLE DISEASE? ☐ None ☐ Cold sores ☐ Fungus *(athletes foot, etc.)* ☐ Shingles ☐ Warts
SKIN, MUSCLE, JOINT, OR BONE DISEASE? ☐ NO ☐ YES If yes, explain: _____
TRAUMA, INJURY, OR FRACTURES? ☐ NO ☐ YES If yes, explain: _____

HAVE YOU EVER REFUSED A RECOMENDED SURGERY? ☐ NO ☐ YES, explain:_____
HAVE YOU EVER HAD BLOOD TRANSFUSION? ☐ NO ☐ YES, explain:_____
HAVE YOU OR ANYONE IN YOUR FAMILY HAD PROBLEMS WITH ANESTHESIA? ☐ NO ☐ YES, explain:_____

SKIN: Check (√) conditions you currently have or have had in the past.

HISTORY OF POOR SCARRING? ☐ None ☐ Hypertrophic scars ☐ Keloid scars ☐ Other: _____
PERMANENT MAKEUP? ☐ NO ☐ YES If yes, location: _____
WHEN EXPOSED TO THE SUN DO YOU (choose only one): ☐ 1- always burn, never tan ☐ 2- burn easily, tan minimally
☐ 3- burn moderately, tan minimally ☐ 4- burn minimally, always tan well ☐ 5- rarely burn, tan profusely ☐ 6- never burn
ETHNITICITY/NATIONALITY? _____

SURGERIES AND HOSPITALIZATIONS ☐ None

Date	Description	Date	Description

REVITALIZE
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FEMALES ONLY:

Last Menstrual Period _____
☐ Menopausal ☐ Post-menopausal
Are you using:
☐ Hormone replacement therapy
☐ Oral contraceptives

Number of Pregnancies:_____
Number of Live Births: _____
Number of Miscarriages: _____
Number of Abortions: _____

Last mammogram: _____
Are you pregnant? ☐ NO ☐ YES
Are you planning a pregnancy?
☐ NO ☐ YES, when: _____
Are you nursing: ☐ NO ☐ YES

MEDICATIONS AND SUPPLEMENTS: List ALL medications and supplements you are currently taking.

☐ None ☐ List attached with the following information.

Medication or Supplement	Dose	Frequency	Reason for Taking

ARE YOU TAKING ASPIRIN OR OTHER BLOOD THINNERS? ☐ NO ☐ YES, what and how often: _____
DO YOU USE ANY EYEDROPS? ☐ NO ☐ YES, what and how often: _____

ALLERGIES/SENSITIVITIES: Check (√) if you currently have or have had allergies/sensitivities to any of these substances in the past.

☐ None ☐ Latex ☐ Soaps or Disinfectants ☐ Environmental ☐ Food ☐ Fumes ☐ Citrus ☐ Herbs ☐ Cosmetics
☐ Pigments/Dyes ☐ Metal ☐ Light ☐ Heat ☐ Cold
☐ Medications or other, if yes list medication and reaction: _____

FAMILY HISTORY: Check (√) if **any blood relative has ever had** any of medical issues and note the relationship to you.

√	Medical Issue	Relationship	√	Medical Issue	Relationship
	Autoimmune disease			High Blood Pressure	
	Cancer (type:_____)			Kidney Disease	
	Cancer (type:_____)			Liver Disease	
	Cancer (type:_____)			Stroke	
	Diabetes			Other: _____	
	Heart Disease			Other: _____	

SOCIAL HISTORY

Nicotine Use? ☐ NO ☐ YES Type: _____ Amount: _____	Alcohol Use? ☐ NO ☐ YES Amount: _____	Drug Use? ☐ NO ☐ YES Type: _____ Amount: _____	Caffeine Use? ☐ NO ☐ YES Amount: _____

I certify that the above information is correct to the best of my knowledge. I will not hold Revitalize Plastic Surgery and Medical Spa and their providers responsible for any omissions/errors I have made in completing this form. This information is confidential and will not be released without consent.

Patient Signature: _____ Date: _____ Reviewed By:_____ Date: _____