

MEDICAL HISTORY FORM

Name _____ Primary Physician _____

Present concern for which you are seeing Dr. Austin: _____

Other physicians, including plastic surgeons, you have consulted about this concern (include dates): _____

I would like additional information on : Breast Implants Tummy Tuck Liposuction Botox® Restylane®
 Skin Care Products Chemical Peels Fine Lines & Wrinkles Face Lift Eyelids

Allergies

Frequency and duration of use

- 1) _____ Coffee/Tea _____ /day for _____ yr.
2) _____ Tobacco _____ /day for _____ yr.
3) _____ Alcohol _____ /day for _____ yr.

Personal Medical History

Have you had any disorders of the Following

	Yes	No	Yes	No
Eyes & Ears	<input type="checkbox"/>	<input type="checkbox"/>	Nervous System	<input type="checkbox"/> <input type="checkbox"/>
Nose / Sinus & Throat	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/> <input type="checkbox"/>
Heart / Blood Vessels	<input type="checkbox"/>	<input type="checkbox"/>	Bones / Joints	<input type="checkbox"/> <input type="checkbox"/>
Breasts	<input type="checkbox"/>	<input type="checkbox"/>	Urinary System	<input type="checkbox"/> <input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/> <input type="checkbox"/>
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	Reproductive System	<input type="checkbox"/> <input type="checkbox"/>

Notes _____

All Medications presently using and dosages/frequency

- 1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Major Injuries/Illness

Year/Duration

- 1) _____
2) _____
3) _____
4) _____
5) _____

Age **State of Health**

Mother _____
Father _____
Brother(s) _____
Sister(s) _____

Family Medical History

Has any relative had:

	Yes	No
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>

Previous Operations

- 1) _____
2) _____
3) _____
4) _____
5) _____

Children

- Do you take aspirin products regularly? _____ Yes No
- Do you have high blood pressure? _____ Yes No
- Do you have shortness of breath with walking or when lying down? _____ Yes No
- Do you get chest pain regularly? _____ Yes No
- Have you ever been found to have a heart murmur? _____ Yes No
- Have you ever had scarlet fever or rheumatic fever? _____ Yes No
- Do you have frequent infectious boils? _____ Yes No
- Have you ever taken steroid medications, cortisone, or ACTH? _____ Yes No
- Have you ever had a bad reaction to local anesthetic? _____ Yes No
- Does your religion prohibit blood transfusions? _____ Yes No
- Do you have unusual bleeding from cuts, surgery, or tooth extractions? _____ Yes No
- Do you form large scars or keloids? _____ Yes No
- Have you ever had psychiatric care or been advised to see a psychiatrist? _____ Yes No
- Do you have or have you had any significant emotional problems? _____ Yes No

Height _____ Ft. _____ In. Weight _____ lbs. Weight change past year of _____ lbs. Loss Gain Date of last menstrual period _____

Date of last physical exam: _____ Did it include EKG? Yes No Chest x-ray Yes No Examining Doctor _____