# NORTHERN JERSEY PLASTIC SURGERY CENTER, LLC

PATIENT HISTORY QUESTIONNAIRE

Name: _____ Height _____Weight _____ Date: ___ / ___ /___

Reason for today's visit: _____

- Are you currently being treated for any significant illness other than colds, flu or virus? If so, please explain:

_____

_____

| Do you have any of the following conditions: | | | If Yes, please explain: |
|---|---|---|---|
| Cardiac History | No | Yes | _____ |
| Diabetes | No | Yes | _____ |
| Asthma | No | Yes | _____ |
| Hepatitis | No | Yes | _____ |
| Bleeding Problems | No | Yes | _____ |
| Hypertension | No | Yes | _____ |
| OTHER CONDITION? | No | Yes | _____ |

- Have you had any surgical procedures in the past?

| Date (mm/yy) | Type of Surgery | Name of Doctor | Hospital |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

- Do you have allergies to Medications?
  Penicillin: No Yes If yes, please specify: _____
  Any others: No Yes If yes, please specify: _____

- What antibiotics have you tolerated? _____
- Are you presently taking any medications?
  Aspirin: No Yes
  Oral Contraceptives: No Yes
  Blood Thinners: No Yes
  Any others, including Over the Counter and Herbal Remedies:
  If yes, please specify below:

| Name of Medication | Dosage | Frequency |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

- Do you smoke cigarettes? No Yes If so, how many packs per day? _____
- Alcohol use? No Yes How much/often? _____

***** If you are using any controlled substance, please bring this to your doctor's attention.*****