NORTHERN JERSEY PLASTIC SURGERY CENTER, LLC

PATIENT HISTORY QUESTIONNAIRE

Name: ________________________________ Height _________Weight ___________ Date: ___ / ___ /___

Reason for consultation: ____

Do you have any of the following medical conditions:

Arthritis	No	Yes	Heart Problems	No	Yes
Asthma	No	Yes	Infections	No	Yes
Bleeding Problems	No	Yes	Migraines	No	Yes
Cancer	No	Yes	Nerve Problems	No	Yes
Deep vein thrombosis/DVT	No	Yes	Thyroid	No	Yes
Depression	No	Yes	Stroke	No	Yes
Diabetes	No	Yes			

Please list any other conditions/illnesses not indicated above:

____

____

Mammogram (Date) ____________ **Results:** Normal / Abnormal **Facility** _______________________

Pregnancies: ______ **C-Sections:** _____

Past surgical procedures:

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

Allergies:

Antibiotics:	No	Yes	If yes, please specify: ____________________________________
Medication:	No	Yes	If yes, please specify: ____________________________________
Food:	No	Yes	If yes, please specify: ____________________________________
Tape/Adhesives:	No	Yes	If yes, please specify: ____________________________________

Are currently taking any medications: Yes / No (If yes, please specify below. Also, please include over the counter and herbal remedies)

Name of Medication	Dosage	Frequency

Do you use any nicotine products, cigarettes or vapes? No / Yes

Do you consume alcohol? No / Yes

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my health.

Patient Signature ____ Date ____________________________