BARBER
Facial Plastic Surgery

Patient Questionnaire and Medical History Form

Name: ____ Date: ________________

DOB: _________________________ Height: __________ Weight: _______________

Who is your primary physician? ____
May we contact them to discuss your medical history if necessary? Yes No

Please answer all questions below as they relate to you.
(If a question is not applicable to you then put "**NA**" in the answer space.)

Medical Problems: ____

Prior Surgeries/Date of Surgery: ____
(Include cosmetic)

Complications/Anesthetic problems from prior surgery:________________________________

Family history of medical problems: (Circle) Heart problems/ Bleeding tendencies/ High blood pressure/ Diabetes/ Thyroid problems/ Excessive bruising/ Excessive scarring/ Psychiatric or nerve problems/ Poor or delayed healing.
Other: ____

Allergies and/or Sensitivities and Associated Reactions:________________________________
____

Are you allergic to any of the following? (Circle) Latex/Iodine/Shell fish/Soy products/
Egg products/Tape/Suture Material/None of the above. Reaction: _________________________

Medications/Doses/Frequency: ____
____

Vitamins/Herbs/Weight Loss Products:____
(The use of herbs, weight loss products, alcoholic beverages and tobacco products should be discontinued 2 weeks prior to surgery.)

Do you use tobacco? No ___ Yes____ Type ____________Amount _________ Prior Use ________

Do you drink alcoholic beverages? No ____ Yes____ What _________ Frequency ______________

Have you ever had a drug or alcohol abuse problem? Yes No
Explain:____

Have you ever been under the care of a psychiatrist? Yes No
Explain: ____

Females Only: Are you pregnant? Yes No (Please Circle)

Are you Nursing? Yes No (Please Circle)

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System Review

(Please answer yes or no to the following as it pertains to you)

General Health

Are you in good health	Yes	No
Any recent weight change	Yes	No
Any problems with healing	Yes	No
Do you bruise easy	Yes	No
Any problems with anemia	Yes	No
Any problems with sleeping	Yes	No
Do you have frequent headaches	Yes	No
Do you exercise regularly	Yes	No
Do you get sick easily	Yes	No

Skin

Problems with skin rashes	Yes	No
Problems with sensitive skin	Yes	No
Any complexion problems	Yes	No
Skin color problems	Yes	No
History of skin cancer	Yes	No
Do you use tanning beds	Yes	No
Do you sun tan frequently	Yes	No

Gastrointestinal

Loss of appetite	Yes	No
Nausea or vomiting	Yes	No
Heart burn or reflux problems	Yes	No
Liver problems	Yes	No

Neurological

Light headed or dizzy	Yes	No
History of stroke	Yes	No
History of paralysis	Yes	No
History of head injury	Yes	No
History of nervous breakdown	Yes	No
Have you ever had a seizure	Yes	No

Dental

Have you ever worn braces	Yes	No
Do you have an overbite	Yes	No
Do you have TMJ problems	Yes	No
Do you snore	Yes	No
Do you have Sleep Apnea	Yes	No
Do you use Nasal CPAP	Yes	No
Do you get fever blisters often	Yes	No

Heart and Lungs

Do you have heart problems	Yes	No
History of chest pain	Yes	No
History of irregular heart beats	Yes	No
Any problems with shortness of breath	Yes	No
History of heart attack	Yes	No
Swelling of feet, ankles or hands	Yes	No
Muscle discomfort with walking	Yes	No
Problems with asthma or wheezing	Yes	No
Do you ever spit up blood	Yes	No

Head and Neck

Do you have visual problems	Yes	No
Any problems with dry eyes	Yes	No
Any problems with double vision	Yes	No
Do you have hearing problems	Yes	No
Nasal breathing problems	Yes	No
History of nasal fracture	Yes	No
History of frequent sinus infections	Yes	No

Musculoskeletal

Joint stiffness, swelling or pain	Yes	No
Weakness of muscles or joints	Yes	No
Any numbness or tingling sensations	Yes	No
Any limited motions	Yes	No

Endocrine/Immune

Thyroid problems	Yes	No
Excessive thirst or urination	Yes	No
Heat or cold intolerance	Yes	No
Are you HIV positive	Yes	No
Do you have AIDS	Yes	No
Any history of sexually transmitted disease	Yes	No

Other

Do you have hay fever or allergies	Yes	No
Any problems with depression	Yes	No
Are you a nervous person	Yes	No
Are you easily upset or irritated	Yes	No
Do you tend to hold "grudges"	Yes	No
Are you afraid of needles	Yes	No
Are you claustrophobic	Yes	No

Do you accept the fact that every medical and surgical treatment is associated with risks and other imponderables?
Yes No __________ (Initial)

Do you accept the fact that the practice of plastic surgery and medicine in general is an imperfect art and science and therefore we cannot guarantee a perfect result with any surgery or treatment? Yes No __________ (Initial)

Please list any other medical problems that have not been covered: ____
____

Signed: ____ Date: ______________________________