PATIENT MEDICAL HISTORY

Patient Name: _____ D.O.B: _____

I. Medical Exclusions

1. Have you had a heart attack within the past 12 months?	☐Yes	☐No
2. Are you currently pregnant?	☐Yes	☐No
3. Are you currently undergoing radiation therapy or chemotherapy for cancer?	☐Yes	☐No
4. Have you had a history of a connective tissue disorder (e.g., Ehlers Danlos Syndrome)?	☐Yes	☐No
5. Do you have severe emphysema or another condition that is oxygen-dependent (e.g., COPD)	☐Yes	☐No

II. Medical History

Please respond to the following conditions:

1. Have you had surgery in the facial area within the previous 9 months?	☐Yes	☐No
2. Limited neck mobility?	☐Yes	☐No
3. Asthma that is inhaler-dependent or other lung problems?	☐Yes	☐No
4. Bleeding disorder?	☐Yes	☐No
5. Abnormal scarring?	☐Yes	☐No
6. Reaction to lidocaine or latex?	☐Yes	☐No
7. Serve dry eyes?	☐Yes	☐No
8. Are you currently taking Coumadin, Plavix or Aspirin on Dr.'s orders?	☐Yes	☐No
9. HIV/AIDS?	☐Yes	☐No
10. Kidney insufficiency?	☐Yes	☐No
11. Liver insufficiency or cirrhosis?	☐Yes	☐No
12. Phlebitis or blood clots?	☐Yes	☐No
13. Diabetes that is not controlled?	☐Yes	☐No
14. Angioplasty with stent placement?	☐Yes	☐No
15. Heart disease or heart problems?	☐Yes	☐No
16. Heart catheterization/stress test?	☐Yes	☐No
Date: _____ ☐Normal ☐Abnormal		
17. High blood pressure?	☐Yes	☐No
☐High ☐Low ☐Normal 120/80		
18. History of aortic aneurysm?	☐Yes	☐No
19. History of heart attack?	☐Yes	☐No
20. History of stroke?	☐Yes	☐No
21. Do you have a pacemaker?	☐Yes	☐No
22. Angina or chest pain w/ exercise?	☐Yes	☐No
23. Are you a current smoker?	☐Yes	☐No
24. History of seizure disorder?	☐Yes	☐No

III. Anything else we should know?

Please list anything your doctor should know about your health, including and drug allergies, previous surgeries, other medical problems or special concerns:

I certify that I have listed all of my current medications, allergies, hospitalizations, medical conditions and previous surgeries to the best of my knowledge and ability.

_____ _____

Patient Signature Date

Med Hx confirmed as up-to-date _____ _____

Surgeon's initials Date (must be day of surgery)