Facial Plastic Surgery of Beaumont
William O'Mara, M.D.

Patient History Form

Name_____**Date**_____

1) **Reason for visit:**_____

Do you currently have or have had these conditions, symptoms:

Y N Frequently tired
Y N Bronchitis
Y N Sinus problems
Y N Hay fever/allergies
Y N Bleeding tendencies
Y N Irregular/fast heart
Y N Transfusions/reactions
Y N Diabetes
Y N Hepatitis
Y N Kidney/bladder problems
Y N Stomach/bowel problems
Y N Convulsions/epilepsy/fits
Y N Glaucoma
Y N Alcohol abuse
Y N AIDS or exposure to AIDS
Y N Fever
Y N Herpes Simplex
Y N Skin Disorders

Y N Pneumonia
Y N Tuberculosis
Y N Heart Attack
Y N Heart disease
Y N Anemia
Y N Thyroid problems
Y N History of numbness tingling in arms/legs
Y N Hiatal hernia
Y N Fainting spells
Y N Other eye problems
Y N Drug abuse
Y N History of latex allergy
Y N Weight loss
Y N Asthma
Y N Shortness of breath
Y N Acne, if yes, have you taken medication? _____

Y N Pulmonary problems
Y N High blood pressure
Y N Chest pain
Y N Swollen glands
Y N Stroke
Y N Psychiatric condition
Y N Loss of appetite
Y N Chronic cough
Y N Hoarseness
Y N Heart murmur
Y N Pacemaker
Y N Yellow jaundice
Y N Migraines
Y N Emphysema
Y N Liver
Y N High Cholesterol

Current Medications: *Include over the counter medications & any herbal supplements and vitamins*

_____
_____
_____
_____
_____
_____
_____

Medication allergies/Type of Reaction:

_____
_____
_____
_____
_____
_____
_____

2) **Have you ever been hospitalized? Yes_____ No_____ For what condition?**

_____
_____

List previous Surgeries | Type of Anesthesia | Date & place of surgery

_____
_____
_____
_____
_____

*Also list injectables: Botox, Dysport, Collagen fillers or fat injections.

3) Family History:

Father (circle) Living Deceased Cause_____
Mother (circle) Living Deceased Cause_____
Siblings (Number) Living Deceased Cause_____
Children (Number) Living Deceased Cause_____

Is there any family history of:
Y N Cancer Who?_____ Cancer Location_____
Y N Skin Disorders Y N Bleeding
Y N Allergies Y N Sinus problems

Have you or any member of your family ever had an unusual reaction to anesthetic? Y N
Please describe_____
_____

4) Do you smoke? Y N If Yes, how much?_____pkg/day Duration _____years
If No, did you ever smoke? Y N When did you quit? _____
Do you use smokeless tobacco? Y N
If the patient is a child, does anyone living in the household smoke? Y N

5) Do you drink alcoholic beverages? (circle) Daily Occasionally Rarely Never
How much caffeine do you consume daily? _____cups/glasses (coffee, colas, etc)
Do you regularly add salt to your food? Y N

6) Females: Last menstrual period? _____Are you pregnant now? Y N

7) Last time you tanned._____ Type: Tanning bed_____ Sun_____ Chemical_____

7) If you need a blood transfusion to save your life would you accept blood products?

Yes_____ No_____ <u>If the answer is no, please discuss with the doctor.</u>

8) Occupation: _____

9) Current physician: _____

Are you under the care of a physician at this time? If so, for what? _____

Primary Pharmacy: _____

10) Do you wear contacts? Y N
Do you get fever blisters often? Y N
Have you ever had an issue with your nerves or muscles? Y N

11) Is there any other information we should be aware of concerning your health?

_____

_____ _____
Patient/Guardian Signature Physician Signature