FACES FIRST HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Full Name _____ Male ☐ Female☐ Date of Birth _____

Name of Primary Care (Family) Physician _____ **Address** _____

CURRENT MEDICATIONS:

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)
☐ **No** ☐ **Yes If yes, please list below *include dosages*.**

Medication Name	Dosage	How often taken

MEDICATION ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ No ☐ Yes
If yes, please list below.

Name of Medication	Type of Reaction

PAST HEALTH HISTORY:

Have you ever been *DIAGNOSED* with any of the following problems?

***Eye Disease*:**
Cataracts ☐ **Yes**
Glaucoma ☐ **Yes**
Macular degeneration ☐ **Yes**
Poor Vision ☐ **Yes**

Ears:
Ear Infections ☐ **Yes**
Hearing Loss ☐ **Yes**
Dizziness (Vertigo) ☐ **Yes**
Ear Pain ☐ **Yes**

***Nose and Sinus*:**
Nasal obstruction ☐ **Yes**
Nasal/Sinus infection ☐ **Yes**
Allergies ☐ **Yes**

Mouth and Throat:
Tonsillitis/Enlarged tonsils ☐ **Yes**
Mouth/Throat infections ☐ **Yes**
Snoring ☐ **Yes**
Sleep Apnea ☐ **Yes**
-- on CPAP ☐ **Yes**

Heart and Blood Vessels:
Arrhythmias ☐ **Yes**
Congestive Heart Failure ☐ **Yes**
Heart Disease ☐ **Yes**
High Blood pressure ☐ **Yes**

Lungs and Respiratory:
Blocked arteries ☐ **Yes**
Asthma ☐ **Yes**
Chronic bronchitis ☐ **Yes**
Emphysema ☐ **Yes**

***Stomach and Digestive*:**
Gastritis ☐ **Yes**
Stomach Ulcers ☐ **Yes**
Colitis ☐ **Yes**
Crohn's Disease ☐ **Yes**
Hepatitis ☐ **Yes**
Reflux/GERD ☐ **Yes**

***Kidney/Bladder and Prostate*:**
Kidney Infections ☐ **Yes**
Bladder Infections ☐ **Yes**
Prostate Infections ☐ **Yes**
Kidney Stones ☐ **Yes**
Bladder Stones ☐ **Yes**

***OB/GYN*:**
Are you pregnant? ☐ **Yes**

***Bones, Joints and Muscles*:**
Arthritis ☐ **Yes**

***Mental & Emotional*:**
Depression ☐ **Yes**
Anxiety ☐ **Yes**

Endocrinology (Glands, Hormones):
Diabetes ☐ **Yes**
What type?_____
insulin? ☐ **Yes**
Thyroid disorders ☐ **Yes**

Brain and Nervous System:
ALS ☐ **Yes**
Multiple Sclerosis (MS) ☐ **Yes**
Myasthenia Gravis ☐ **Yes**
Stroke (CVA) ☐ **Yes**

***Blood & Lymph Node problems*:**
Anemia ☐ **Yes**
Bleeding Disorder ☐ **Yes**

***Infectious Disease/Immune System Problems*:**
Hepatitis A, B, or C ☐ **Yes**
HIV ☐ **Yes**
Immune System Deficiencies ☐ **Yes**

Cancer:
Prostate ☐ **Yes**
Breast ☐ **Yes**
Colon ☐ **Yes**
Head and Neck Lymphoma ☐ **Yes**
Lung ☐ **Yes**
Skin ☐ **Yes**
Other ☐ **Yes**
-- Chemotherapy ☐ **Yes**
-- Radiation Therapy ☐ **Yes**

SURGERIES AND HOSPITALIZATIONS:

Have you ever had any cosmetic or general surgery? ☐ **No** ☐ **Yes**
If **yes**, please list the procedure, date of surgery, the surgeon, and the hospital where it was performed. (Fill in the information as best as you possibly can?
Surgery_____Date_____Surgeon_____Hospital_____
Surgery_____Date_____Surgeon_____Hospital_____
Surgery_____Date_____Surgeon_____Hospital_____

Have you been hospitalized for any general medical or surgical reason? ☐ **No** ☐ **Yes**
If **yes**, please list the disease/diagnosis, date and the reason for admission?
Disease_____ Date_____ Reason for Admission_____
Disease_____ Date_____ Reason for Admission_____
Disease_____ Date_____ Reason for Admission_____

FAMILY HISTORY:

Specific Anesthesia Problem	☐Mother☐Father☐Brother☐Sister	**Brain and Nervous:**	
Heart and Blood Vessels:		Stroke	☐Mother☐Father☐Brother☐Sister
Heart Disease	☐Mother☐Father☐Brother☐Sister	**Blood & Lymph Node problems:**	
High Blood Pressure	☐Mother☐Father☐Brother☐Sister	Bleeding/clotting problem	☐Mother☐Father☐Brother☐Sister
Lungs and Respiratory:		**Cancer**_____	☐Mother☐Father☐Brother☐Sister
Asthma	☐Mother☐Father☐Brother☐Sister	**Other**_____	☐Mother☐Father☐Brother☐Sister

SOCIAL HISTORY:
What is or was your occupation? _____ ☐ Check here if you are retired.

Have you ever used tobacco in any form?
☐ **No** ☐ **Yes**
If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _____		
Other: (list type) _____		

Do you consume alcohol? ☐ **No** ☐ **Yes**
If yes, please complete the following:

What Type? (beer, wine, hard liquor)	How Much?	How often? (daily, weekly, monthly, rarely)

Are you or have you been exposed to second hand smoke? ☐ **No** ☐ **Yes**

Do you use drugs recreationally? ☐ **No** ☐ **Yes**

WHAT SURGICAL PROCEDURES ARE YOU INTERESTED IN?

☐ Botox
☐ Browlift
☐ Chin
☐ Eyelids
☐ Facelift or Necklift
☐ Facial liposuction
☐ Fat Transfer
☐ Fillers
☐ Laser resurfacing
☐ Lip Enhancement
☐ Protruding ears
☐ Removal of cysts, warts, moles, etc.
☐ Rhinoplasty
☐ Other

What, specifically, do you wish to have corrected?

1._____

2. _____

3. _____

When did you begin to consider surgical correction?_____

Why have you decided to have it done at this time?_____

Have you discussed this procedure with your family? ☐ No ☐ Yes Are they agreeable? ☐ No ☐ Yes