Aesthetic Surgery of Charlotte
11835 Southmore Drive Suite 202
Charlotte, NC 28277
ph: (704) 837-1150 **fx**: (704) 837-1156
www.aestheticsurgerycharlotte.com

HEALTH QUESTIONNAIRE

First name _____ Middle Name _____ Last Name _____

Birthdate _____ How did you hear about us? _____

Address _____

City _____ State _____ Zip code _____

Please list the phone numbers and email where we can reach you:

	Phone number/email	Preferred method of contact	OK to leave a message?
Cell phone		❑	❑ Yes ❑ No
Home phone		❑	❑ Yes ❑ No
Work phone		❑	❑ Yes ❑ No
Other phone		❑	❑ Yes ❑ No
Email address		❑	❑ Yes ❑ No

Please list any other contacts we can speak to in case of emergency or regarding your health:

Emergency Contact _____ Relationship to patient _____ Phone _____

Authorized Medical Info. Contact _____ Relationship to patient _____ Phone _____

Referring physician _____ Phone _____

Primary care provider _____ Phone _____

Preferred Pharmacy _____ Phone _____

	Past medical history		
❑	- No Pertinent Past Medical History	❑	History of staph infection
❑	Artificial heart valve	❑	HIV
❑	Asthma or emphysema	❑	Joint problems or artificial joint
❑	Bleeding tendency	❑	Keloids or abnormal healing
❑	Blood clot	❑	Kidney disease
❑	Cancer (other than skin)	❑	Leg swelling or varicose veins
❑	Cold sores	❑	Liver disease or hepatitis
❑	Depression or anxiety	❑	Neurologic disorder
❑	Diabetes	❑	Organ Transplant
❑	Eye or vision problems	❑	Pacemaker / Defibrillator
❑	Hay fever (seasonal allergies)	❑	Radiation Therapy
❑	Heart Disease	❑	Stroke
❑	High Blood Pressure	❑	Thyroid Disorder
❑	High Cholesterol	❑	Other History

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	Current medications (if none, please write none)			
	Medication Name	Dosage	# of times daily	Notes
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

	Allergies (if none, please write none)	
	Reaction	**Notes**
1		
2		
3		

	Family history	Effected family member	Notes
❑	- No Contributing Family History		
❑	Adopted		
❑	Basal or squamous cell carcinoma		
❑	Malignant Melanoma		
❑	Atopy (Eczema, asthma, or hay fever/seasonal allergies)		
❑	Psoriasis		
❑	Pancreatic cancer		
❑	Bleeding disorder or blood clots		
❑	Other Family History		

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	Past surgeries/hospitalizations		
	Surgery	**Date**	**Notes**
1			
2			
3			
4			
5			
6			

	Ability to Heal	
1	Does your skin appear fragile, burns easily?	❑ Yes ❑ No
2	Do you form thick or raised scarring from a cut or burn?	❑ Yes ❑ No
3	Do you wax or use depilatories on your face?	❑ Yes ❑ No
4	Do you ever get cold sores?	❑ Yes ❑ No

	Female Questions	
1	Do you have regular periods?	❑ Yes ❑ No ❑ N/A
2	When was your last menstrual period?	❑ Yes ❑ No ❑ N/A
3	Are you going through menopause?	❑ Yes ❑ No ❑ N/A
4	Are you currently pregnant or lactating?	❑ Yes ❑ No ❑ N/A
5	During pregnancy, did you ever get hyperpigmentation or masking?	❑ Yes ❑ No ❑ N/A
6	How many pregnancies?	❑ Yes ❑ No ❑ N/A
7	How many live births?	❑ Yes ❑ No ❑ N/A
8	Did you breast feed? If yes, how many times?	❑ Yes ❑ No ❑ N/A

	Cancer History	Location	Treatment
❑	Breast Cancer		
❑	Malignant Melanoma		
❑	Ovarian Cancer		
❑	Skin Cancer		
❑	Other		

Height / Weight		
Height	**Weight (lbs)**	**Highest Weight (lbs)**

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HEALTH QUESTIONNAIRE

Social history		Personal Habits	
Marital Status:	❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Domestic partner	Illegal Drugs:	❑ denies using illegal drugs ❑ admits to using illegal drugs ❑ admits to history of drug abuse
Occupation:		Tobacco Use:	❑ Current every day smoker ❑ Current some day smoker ❑ Former smoker ❑ Never smoker ❑ Smoker, current status unknown ❑ Unknown if ever smoked ❑ Heavy tobacco smoker ❑ Light tobacco smoker Date Started: _____ Date Ended: _____
Alcohol:	❑ denies alcohol use ❑ admits alcohol use socially ❑ admits alcohol use daily ❑ admits to history of alcoholism		
STD:	❑ denies STD history ❑ admits STD history ❑ blood transfusion		

	Allergic/Immunologic/Infectious	
1	Allergic/Immunologic/ Infectious Problems	❑ Yes ❑ No
2	HIV/AIDS	❑ Yes ❑ No
3	Tuberculosis (TB)	❑ Yes ❑ No
4	Autoimmune disorder	❑ Yes ❑ No
5	Other	❑ Yes ❑ No

	Implant/Device History	
1	Pacemaker	❑ Yes ❑ No
2	Breast Implants	❑ Yes ❑ No
3	Other Implants	❑ Yes ❑ No
4	Tissue Expander	❑ Yes ❑ No
5	Joint or other replacement implant	❑ Yes ❑ No
6	Other	❑ Yes ❑ No

REVIEW OF SYSTEMS:
Please answer the following yes/no questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

HEMATOLOGIC/ONCOLOGIC	Yes	No
Breast Disease		
Bleeding Tendency		
Easy Bruising		
Anemia		
Sickle Cell Disease		
Blood Clots in Legs		
Blood Clots in Lungs		
Radiation Therapy		
CARDIOVASCULAR	**Yes**	**No**
High Blood Pressure		
Heart Attack		
Angina/Chest Pain		
Heart Bypass Surgery		
Pacemaker		
Heart Failure		
Irregular Heartbeat		
Do you exercise? Comments:		
NEUROLOGICAL	**Yes**	**No**
Stroke		
Seizures		
Dizziness		
Headache		
Depression		
Anxiety		
Bi-Polar		
ENDOCRINE	**Yes**	**No**
Diabetes		
Thyroid Disease		
Taken Steroids		

RESPIRATORY	Yes	No
Asthma		
Bronchitis		
Emphysema		
Recent Chest Infection		
Shortness of Breath (at rest/on exertion)		
Dry Cough		
Cough with Sputum		
Sleep Apnea		
Use a C-Pap machine?		
URINARY/REPRODUCTIVE	**Yes**	**No**
Kidney Disease		
Urinary Disease		
Dialysis		
MUSCULOSKELETAL	**Yes**	**No**
Sciatica		
Herniated Disk (neck, back)		
Arthritis		
Rheumatoid Arthritis		
Neck, Back, Arm, Leg Problems		
Back/Neck Surgery		
INFECTIOUS/GASTROINTESTINAL	**Yes**	**No**
Jaundice		
Hepatitis		
Stomach Ulcers		
Hiatal Hernia		
Heartburn		
HIV/AIDS		
SKIN	**Yes**	**No**
Skin Cancer (Basal Cell, Squamous Cell, Melanoma		
Staph Infection		
Problems with Scarring (E.g. keloids, widened, etc.)		

Patient or legal guardian signature _____ **Date** _____

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Reviewed by	Date