**Health Questionnaire** **PATIENT NAME:**________________________

When was your last **physical examination**? ____/____/____

How is your **general health**? ________________________________________

Who is your **primary physician**? ____________________________________

What **medical conditions** are you presently being treated for?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please list your **previous surgeries and any complications including anesthesia reactions:**

| Surgery | Date | Complications |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Please list any reasons for **hospital admissions:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Do any illnesses run in your **family medical history?** (include anesthesia and bleeding problems)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Has any of your relatives had **breast cancer**? YES / no
if so, who? ____________________________________

When was your last **mammogram**?
____/____/____

Please list all **medications to which you have allergies or intolerances:**

| Medication Allergy | Reaction |
|---|---|
| | |
| | |
| | |

Please list all **medications you are currently taking:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

What is your **height**? _________ What is your **weight**? _________

**Health Questionnaire** **PATIENT NAME:**________________________

**Please circle the appropriate answer**

| EYE | yes | no | HEART/LUNGS | yes | no |
|---|---|---|---|---|---|
| Visual Loss | Y | N | Heart attack | Y | N |
| Dry eyes | Y | N | Congenital heart disease | Y | N |
| Itchy or irritated eyes | Y | N | Heart murmur | Y | N |
| Blurred or double vision | Y | N | Palpitations / irregular heart beat | Y | N |
| Crossed or lazy eyes | Y | N | High blood pressure | Y | N |
| Cornea problems | Y | N | Stroke | Y | N |
| Thyroid eye disease | Y | N | Shortness of breath | Y | N |
| Wear glasses or contacts | Y | N | Chronic lung disease | Y | N |
| Previous eyelid surgery | Y | N | Cough | Y | N |
| **NOSE** | | | Asthma | Y | N |
| Difficulty breathing through nose | Y | N | **BREAST** | | |
| Previous nose injury | Y | N | Breast pain or discomfort | Y | N |
| Nasal Allergies | Y | N | Breast cysts or lumps | Y | N |
| Nose bleeds | Y | N | Previous breast biopsies | Y | N |
| Sinus conditions | Y | N | Breast cancer | Y | N |
| Previous nose or sinus surgery | Y | N | **OTHER** | | |
| **FACE** | | | Liver disease(hepatitis, cirrhosis) | Y | N |
| Radiation to face or neck | Y | N | Kidney or bladder problems | Y | N |
| Facial paralysis or weakness | Y | N | Bleeding disorders | Y | N |
| Acne or facial skin problems | Y | N | Easy bleeding or bruising | Y | N |
| Previous facial surgery | Y | N | History of blood clots | Y | N |
| **PSYCHIATRIC** | | | Blood transfusions | Y | N |
| Any recent crisis in your life? | Y | N | Autoimmune disease | Y | N |
| Have you ever: | | | Unusual scarring | Y | N |
| been treated for depression? | Y | N | Thyroid disease | Y | N |
| been treated for anxiety? | Y | N | Stomach or digestive disease | Y | N |
| received psychiatric treatment? | Y | N | Spine or back problems | Y | N |
| been hospitalized for psychiatric treatment? | Y | N | Diabetes | Y | N |
| **LIFESTYLE** | | | **LIFESTYLE** | | |
| Do you drink alcohol? | Y | N | DO YOU SMOKE? | Y | N |
| If yes how much per week: ______ | | | HAVE YOU EVER SMOKED? | Y | N |
| Do you take recreational drugs? | Y | N | MIGHT YOU BE PREGNANT? | Y | N |
| If yes what kinds: | | | | | |

**Signature:** Date: