

Welcome to the Emory Aesthetic Center! Please help us take the best care for you by providing us with the following important health information. Thank you!



REASON FOR VISIT/AREA OF INTEREST: _____

Do you or a family member work for Emory Healthcare/Emory University? YES NO

Height _____ Weight _____ BMI _____ Age _____

DRUG ALLERGIES? Please specify: _____ NO KNOWN DRUG ALLERGIES

FOOD ALLERGIES? Please specify: _____ NO KNOWN FOOD ALLERGIES

LATEX ALLERGY? YES NO ADHESIVE TAPE ALLERGY? YES NO

PRIMARY CARE PHYSICIAN _____ Date of last physical exam _____

PRIOR SURGERY Procedure _____ Year _____ Surgeon/Location _____
 Procedure _____ Year _____ Surgeon/Location _____
 Procedure _____ Year _____ Surgeon/Location _____
 Procedure _____ Year _____ Surgeon/Location _____

FOR WOMEN

YES NO Personal or family history of breast cancer Bra size _____

YES NO Breast mass YES NO Nipple discharge YES NO Breast pain

YES NO Are you or could you be pregnant? Have you ever had a mammogram? YES NO Date of most recent _____ YES NO

PREGNANCIES Year _____ Vaginal Delivery C-section Year _____ Vaginal Delivery C-section

Year _____ Vaginal Delivery C-section Year _____ Vaginal Delivery C-section

MEDICATIONS: PHARMACY: _____ PHARMACY PHONE: _____

PRESCRIPTION: Medication: _____ Dose _____ Medication: _____ Dose _____
 Medication: _____ Dose _____ Medication: _____ Dose _____
 Medication: _____ Dose _____ Medication: _____ Dose _____

OVER THE COUNTER MEDICATIONS:

Medication: _____ Dose _____ Medication: _____ Dose _____
 Medication: _____ Dose _____ Medication: _____ Dose _____

HERBAL/DIETARY SUPPLEMENTS:

Medication: _____ Dose _____ Medication: _____ Dose _____
 Medication: _____ Dose _____ Medication: _____ Dose _____

MEDICAL HISTORY - DO YOU HAVE OR HAVE YOU EVER HAD:

- YES NO Heart disease (including: heart murmur, pacemaker, catheterization, stents, surgery, mitral valve prolapsed) Specify: _____
- YES NO Chest pain Do you exercise regularly? YES ___ NO ___ What type _____
- YES NO Previous EKG/stress test/echocardiogram Date(s) _____
- YES NO High blood pressure
- YES NO Asthma Hospitalizations YES NO how many _____
- YES NO Lung disease Specify _____
- YES NO Chronic cough
- YES NO Shortness of breath
- YES NO Sleep apnea
- YES NO CPAP machine If YES, do you use it nightly? YES NO
- YES NO Abnormal chest x-ray
- YES NO Kidney disease Specify _____
- YES NO Difficulty voiding
- YES NO Liver disease/hepatitis/jaundice Specify _____
- YES NO Diabetes Since _____ Do you take insulin? YES NO Last Hemaglobin A1C level _____
- YES NO Are you on a special diet? Specify _____

- YES NO Recent weight loss? If yes, was it purposeful? YES NO How much weight loss? _____
 YES NO Anemia _____
 YES NO Epilepsy/Seizures/Stroke/Neurological problems Specify _____
 YES NO Autoimmune disorders/connective tissue disorders/lupus/sarcoid Specify _____
 YES NO Psychological conditions (depression/anxiety, bipolar, schizophrenia, etc.) Specify _____
 YES NO Thyroid or goiter problems Specify _____
 YES NO Bowel/colon disease or problems Specify _____
 YES NO Frequent heartburn/indigestion, esophageal reflux, hiatal hernia _____
 YES NO Recent vision change _____
 YES NO Glaucoma _____
 YES NO Dry eyes _____
 YES NO Use eye drops _____
 YES NO Back and/or neck problems Specify _____
 YES NO Muscle weakness Specify _____
 YES NO Hepatitis If yes, type (A, B, C)? _____ Date diagnosed _____
 YES NO HIV If yes, date diagnosed _____
 YES NO MRSA If yes, date diagnosed _____
 YES NO Past/present carrier of other contagious/infectious disease Specify _____
 YES NO Metal implants (back,hip,knee,etc.) Specify _____
 YES NO Exposure to communicable diseases in the past 3 weeks Specify _____
 YES NO Personal or family history of deep venous thrombosis (DVT, blood clots in legs or lungs) _____
 YES NO Personal history of bleeding or clotting abnormality (e.g. Factor V Leiden, lupus anticoagulant) _____
 YES NO Family history of bleeding or clotting abnormality (e.g. Factor V Leiden, lupus anticoagulant) _____
 YES NO History of blood transfusions Specify _____
 YES NO Nose surgery _____
 YES NO Broken bones in face, back, or neck Specify _____
 YES NO Do you or have you ever smoked? Amount per day _____ How many years _____ Year quit _____
 YES NO Use(d) smokeless tobacco How many years _____ Year quit _____
 YES NO Use(d) recreational drugs types(s) _____ How much _____ How many years _____
 YES NO Use(d) alcohol type(s) _____ How much _____
 YES NO Been treated for substance abuse type(s) _____ When _____
 YES NO Steroid use in the past 12 months Specify _____
 YES NO Keloids or unusually large scars _____
 YES NO Frequent infections or boils _____

ANESTHESIA HISTORY

- YES NO Have you ever had a reaction to a regional or local anesthesia injection? If yes, specify _____
 YES NO Have you ever had a general anesthesia? _____
 YES NO Have you ever had problems with anesthesia? Specify _____
 YES NO Have members of your family had problems with anesthesia? Specify _____

DO YOU HAVE OR WEAR ANY OF THE FOLLOWING?

- | | | | |
|----------------------------------------------------------|------------------------|----------------------------------------------------------|-----------------|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Dentures | <input type="checkbox"/> YES <input type="checkbox"/> NO | Contact lens |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Partial plate | <input type="checkbox"/> YES <input type="checkbox"/> NO | Eye glasses |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Bridgework - permanent | <input type="checkbox"/> YES <input type="checkbox"/> NO | Wig/hairpiece |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Caps/Crowns | <input type="checkbox"/> YES <input type="checkbox"/> NO | Hearing aid |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Chipped/Missing teeth | <input type="checkbox"/> YES <input type="checkbox"/> NO | False eyelashes |

I HAVE ANSWERED ALL OF THESE QUESTIONS FULLY AND TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I SHOULD INFORM MY PHYSICIAN IF I EXPERIENCE ANY NEW HEALTH ISSUES OR IF THE STATUS OF MY EXISTING HEALTH ISSUES CHANGES. I AGREE TO HAVE NOTHING BY MOUTH AFTER MIDNIGHT THE NIGHT BEFORE MY SURGERY UNLESS INSTRUCTED TO DO SO.

 Patient Signature _____ Date _____ Parent,Guardian,next of Kin (if patient unable to sign) Relationship _____

(PHYSICIAN ONLY) FORM REVIEWED WITH PATIENT _____, M.D. Date _____

Updated _____ Patient Signature _____ Physician Signature _____