

CONTOUR AESTHETIC SURGERY CENTER

Ali Heidari, D.O.

HEALTH QUESTIONNAIRE

NAME _____ AGE _____ DATE _____

HISTORY OF PAST ILLNESS

Have you ever had:

- | | | | |
|--|--------|----------------------------|---------------|
| MEASLES | YES NO | THYROID DISEASE..... | YES NO |
| MUMPS | YES NO | TUBERCULOSIS | YES NO |
| CHICKEN POX | YES NO | VENEREAL DISEASE | YES NO |
| DIABETES | YES NO | CONGENITAL ABNORMALITIES . | YES NO |
| STROKE | YES NO | HERPES OR COLD SORES | YES NO |
| CANCER | YES NO | NOSEBLEEDS | YES NO |
| EYE DISEASE | YES NO | ULCERS, STOMACH..... | YES NO |
| CHRONIC SINUS | YES NO | HAYFEVER | YES NO |
| CHEST PAIN/ANGINA | YES NO | HORMONE THERAPY | YES NO |
| CHRONIC/FREQUENT COUGH | | | YES NO |
| RHEUMATIC FEVER OR HEART DISEASE | | | YES NO |
| HAVE YOU EVER HAD A TRANSFUSION..... | | | YES NO |
| HAVE YOU EVER HAD BLOOD CLOTS IN YOUR LEGS..... | | | YES NO |
| HAVE YOU HAD DIFFICULTY WITH ANESTHESIA ... | | | YES NO |
| HAVE YOU EVER HAD A BLOOD REACTION | | | YES NO |
| OTHER SERIOUS ILLNESS OR DISEASE | | | YES NO |

EXPLAIN: _____

Have you had any surgery? (Elective, cosmetic, emergency, dental, etc.) _____

Medications you are presently taking:(include herbal supplements, vitamins and birth control pills) _____

Allergies and sensitivities (medication, latex or food) _____

Family history of cancer, diabetes or any disease: _____

Social history: Alcohol _____ Tobacco _____

By signing this form you certify that the above information is honest and detailed to the best of your knowledge. Any known health issues you neglect to inform us of can cause a risk to your health.

Patient's Signature

Date

(rev:10/01)

