Robert Kotler, MD, FACS

PATIENT HISTORY FORM

Today's Date _______________

Name: ____ Birth Date: ________________
Last First Middle

1. Previous Cosmetic Surgeries:

   Type(s): ____

   Date(s): ____

   Doctor(s): ____

Have you ever required narcotics/opioids to control pain for any medical problem or after surgery?

Do you have a particular preference for any one or more pain medications?

2. Family History Medical Condition Age Cause of Death

   Mother: ____

   Father: ____

   Sisters: ____

   Brothers: ____

3. If any diseases occur in family, please list: _____________________________________

   ____

4. Have you ever had any serious childhood diseases? If so, please describe and give age at time of illness: ____

   ____

5. Do you have any allergies? To drugs, skin adhesives, tapes? If so, please list and explain:

   ____

   ____

6. Are you presently under the care of a physician? If so, please give his/her name and the date of your last visit: ____

7. Do you or any member of your family have any bleeding tendency? If so, please explain:

   ____

8. Any blood relative have difficulty during anesthesia? If so, please describe:___________

   ____

Please turn this page over to complete the other side

9. Have you had a problem with local anesthesia, for example, during dental treatment? ____

10. Any unusual experiences with general anesthesia or sedation?______________________

11. Any family history of sickle cell anemia?____
____

12. Did you ever or do you now have any history of heart trouble, asthma, high blood pressure, tuberculosis, kidney disease, liver disease, blood disease, ear or eye trouble, rheumatic fever or arthritis? Any medical problem? ______________________________

PLEASE CIRCLE THOSE THAT APPLY, AND IF EVER HOSPITALIZED FOR THE ABOVE, GIVE THE YEAR, HOSPITAL, AND NAME OF THE DOCTOR BELOW:

____

____

13. Habits:

A. Do you smoke cigarettes?_______How many cigarettes per day?___________

If you did smoke, when did you quit? ____________________

B. Do you drink alcoholic beverages? _______ How much? _______________________

C. Do you now take <u>any</u> medications? _______ If so, please list them below, and include dosages (if known) and how often you take them. Any medication can cause allergic reactions, so it is in your interest to list <u>any drugs</u> that you may be taking, including <u>nonprescription meds</u>, herbals, homeopathics, vitamins, Anacin, Afrin nasal spray, ginko, garlic, etc. ____

____

____

14. Previous surgeries:

A. If you have no surgical history, state "NONE".

B. If any complications occurred, please describe.

<u>Type</u>	<u>Reason</u>	<u>Year</u>	<u>Hospital</u>	<u>Doctor</u>

15. Have you ever had a tubal ligation or hysterectomy? _____ If so, how long ago? __________

16. Do you have any reason to think you may be pregnant? Yes __________ No ____________