ASPEN
FACIAL PLASTIC SURGERY

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PATIENT MEDICAL HISTORY FORM

Patient Name: _____

REASON FOR VISIT: _____

_____

MEDICAL HISTORY

Have you had other aesthetic consultations? □ Yes □ No
Have you had previous treatments to this area? □ Yes □ No
Previous cosmetic / aesthetic surgery? □ Yes □ No
Fillers? □ Yes □ No
Botox? □ Yes □ No
Do you have any implants – facial, joint, breast or otherwise? □ Yes □ No _____
Do you have permanent / tattooed cosmetics □ Yes □ No _____
Do you use or have you ever used Accutane? □ Yes □ No
List skin products you use on a daily basis _____
_____

Do you get cold sores / fever blisters? □ Yes □ No When was your last one? _____
Have you ever had a hypertrophic scar or keloid? □ Yes □ No Where on your body? _____
Do you use tobacco products (including vaping)? □ Yes □ No How much and how often? _____
Do you drink alcohol? □ Yes □ No How much and how often? _____
Have you used or been addicted to other drugs? □ Yes □ No If so, which (marijuana, cocaine, meth, etc.)? _____
Have you ever had a reaction to anesthesia? □ Yes □ No
Has there ever been concern for or have you ever been diagnosed with a body dysmorphic disorder? _____
Do you have allergies? □ Yes □ No
If yes, list allergies and reactions:
_____
_____

LIST ALL CURRENT MEDICATIONS AND SUPPLEMENTS (prescriptions, over the counter medication, vitamins, herbal supplements):

Medication	Dose	Frequency

LIST ALL HOSPITALIZATIONS AND SURGERIES:

_____
_____

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Do you take blood thinners (aspirin / Bayer / Excedrin, Coumadin/ Warfarin, Plavix / Clopidogrel, Xarelto, etc.)? □ Yes □ No
Do you take any non-steroidal pain medicine (Advil / Motrin / Ibuprofen, Alieve / Naproxen, Celebrex, etc.)? □ Yes □ No
If so, which ones? _____
Do you take any diet pills? □ Yes □ No If so, which ones? _____

MEDICAL HISTORY (continued)

Are you pregnant or breastfeeding? □ Yes □ No
Are you legally blind? □ Yes □ No If so, which eye? _____
Do you wear contact lenses? □ Yes □ No

List the following:

Heart disorders (high blood pressure, high cholesterol, heart attack/angina, palpitations/arrhythmias, etc.) _____

Lung/breathing disorders (asthma, Sleep apnea, COPD, etc.) _____

Bleeding/clotting disorders (hemophilia, Factor V Leiden, etc.) _____

Neurological (seizures, stroke, MS, myasthenia gravis, etc.)_____

Endocrine (thyroid disorder, diabetes, etc.) _____

Psychiatric (depression, anxiety, panic attacks, bipolar, etc.) _____

Hematologic (blood clots/been on blood thinners, anemia, etc.) _____

Skin (acne, rosacea, eczema, psoriasis, etc.) _____

Cancer _____

Hepatitis / HIV- AIDS _____

MRSA skin infections _____