

AESTHETIC ASSOCIATES, INC., P.S.
THE SEATTLE FACIAL PLASTIC SURGERY CENTER

NAME			DATE		
BIRTH DATE		GENDER: <input type="checkbox"/> M <input type="checkbox"/> F		ARE YOU OR COULD YOU BE PREGNANT?	
AGE:	HEIGHT:	WEIGHT:	# OF PAST PREGNANCIES		
BMI:					

PLEASE LIST PAST SURGERIES AND YEAR THEY TOOK PLACE

1 _____	4 _____
2 _____	5 _____
3 _____	6 _____

LIST ANY PREVIOUS COMPLICATION WITH SURGERY: _____

CURRENT MEDICAL PROBLEMS: _____

CURRENT MEDICATIONS, PLEASE LIST DOSE AND FREQUENCY: _____

KNOWN DRUG ALLERGIES: _____

ALCOHOL USE <input type="checkbox"/> Y <input type="checkbox"/> N IF SO, AMOUNT: _____ FREQUENCY: _____	TOBACCO USE <input type="checkbox"/> Y <input type="checkbox"/> N IF SO, TYPE: _____ AMOUNT: _____
COFFEE/CAFFEINE USE <input type="checkbox"/> Y <input type="checkbox"/> N IF SO, AMOUNT: _____ FREQUENCY: _____	DRUG USE <input type="checkbox"/> Y <input type="checkbox"/> N IF SO, TYPE: _____ AMOUNT: _____

PARENTS HEALTH (IF DECEASED, INDICATE CAUSE OF DEATH):

SIBLINGS WITH SIGNIFICANT HEALTH PROBLEMS:

PLEASE CIRCLE ALL THAT APPLIES TO YOUR IMMEDIATE FAMILY (MOTHER, FATHER, SIBLINGS, GRANDPARENTS):

DIABETES	HIGH BLOOD PRESSURE	STROKE	BLEEDING DISORDERS	CANCER
ASTHMA	HEART PROBLEMS	EAR SURGERY	EARLY HEARING LOSS	HAYFEVER

I CERTIFY THAT THIS HISTORY FORM IS FILLED OUT COMPLETELY AND ACCURATELY.
I HAVE ANSWERED ALL OF THE QUESTIONS TO THE BEST OF MY KNOWLEDGE

PATIENT SIGNATURE

DATE