

# CONFIDENTIAL HEALTH HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Date of last physical examination: \_\_\_\_\_

Occupation: \_\_\_\_\_

Reason for visit today: \_\_\_\_\_

<b>MEDICATIONS</b> List all medications you are currently taking	<b>ALLERGIES</b> List all allergies

**SYMPTOMS** Check (✓) symptoms you currently have or have had in the past year.

<p><b>GENERAL</b></p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p><b>GASTROINTESTINAL</b></p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p><b>EYE, EAR, NOSE, THROAT</b></p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Flashes <input type="checkbox"/> Vision - Halos	<p><b>MEN only</b></p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other
<p><b>MUSCLE/JOINT/BONE</b> Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p><b>SKIN</b></p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sores that won't heal	<p><b>WOMEN only</b></p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other
<p><b>GENITO-URINARY</b></p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination			<p>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>

**MEDICAL HISTORY** Check (✓) the medical conditions you have or have had in the past.

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia	<input type="checkbox"/> Herpes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio <input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease
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HOSPITALIZATIONS		
Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion?  Yes  No  
 If yes, please give approximate dates: \_\_\_\_\_

OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following:	HEALTH HABITS Check (✓) which substances you use and indicate how much you use per day/week.	PREGNANCY HISTORY		Complications if any
		Year of Birth	Sex of Birth	
<input type="checkbox"/> Stress	<input type="checkbox"/> Caffeine			
<input type="checkbox"/> Hazardous Substances	<input type="checkbox"/> Tobacco			
<input type="checkbox"/> Heavy Lifting	<input type="checkbox"/> Drugs			
<input type="checkbox"/> Other	<input type="checkbox"/> Alcohol			

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

FAMILY HISTORY Fill in health information about your family.						
Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relatives had any of the following Disease Relationship to you	
Father					<input type="checkbox"/> Arthritis, Gout	
Mother					<input type="checkbox"/> Asthma, Hay Fever	
Brothers					<input type="checkbox"/> Cancer	
					<input type="checkbox"/> Chemical Dependency	
					<input type="checkbox"/> Diabetes	
					<input type="checkbox"/> Heart Disease, Strokes	
Sisters					<input type="checkbox"/> High Blood Pressure	
					<input type="checkbox"/> Kidney Disease	
					<input type="checkbox"/> Tuberculosis	
					<input type="checkbox"/> Other	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed By

\_\_\_\_\_  
Date

*A. Chasby Sacks, M.D.*  
*Cosmetic/Plastic Surgery*  
**ARIZONA COSMETIC SURGERY**

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Social Security # \_\_\_\_\_

Phone # \_\_\_\_\_ Cellular # \_\_\_\_\_ Pgr # \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

In case of emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by: (Advertisement) \_\_\_\_\_ Internet Web Site

\_\_\_\_\_ US West DEX - Yellow Pages

\_\_\_\_\_ Finance Company Referral

\_\_\_\_\_ Previous Patient (who?) \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

What procedure(s) are you interested in? \_\_\_\_\_

How do you plan to pay for your surgery: Cash? \_\_\_\_\_ Cashier's Check? \_\_\_\_\_

Credit Card? \_\_\_\_\_ Financing? \_\_\_\_\_

Trade? \_\_\_\_\_

General health good? \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_

Any serious medical problems in the past? \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_

Previous operations or hospitalizations? \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_

Take any medications regularly? \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_

Are you taking any diet pills (PhenFen, etc.)? \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_

Any known drug sensitivities? \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**\*\* We will only use this to send information on Specials and Discounts!!**