



Name: _____ D.O.B. _____

HEALTH DISCLOSURE STATEMENT

ALLERGIES AND SENSITIVITIES Is there any history of skin reaction or other illness following contact with: (If yes, please circle item)

- yes no Penicillin, Sulfa or other antibiotic?
 - yes no Morphine, Codeine, Demerol or narcotic?
 - yes no Novocain, Lidocaine or local anesthetics?
 - yes no Tetanus toxoid or serums?
 - yes no Adhesive tape?
 - yes no Iodine, Betadine, Chlorhexidine or Phisophex ?
 - yes no Tincture of Benzoin?
 - yes no Latex rubber?
 - yes no Other drug medicine of other substance? (if yes list here)
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DRUGS AND MEDICINES Have you, within the last 6 months, taken any of the following: (If yes, please circle item)

- yes no Cortisone, prednisone or ACTH?
 - yes no Diuretics or water pills?
 - yes no Blood pressure medication?
 - yes no Steroids or body building drugs?
 - yes no Seizure medication?
 - yes no Insulin or diabetes medication?
 - yes no Headache or migraine medications?
 - yes no Asthma medication?
 - yes no Phen-Phen or Redux?
 - yes no Birth Control Pills?
 - yes no Antibiotics?
 - yes no Heart medication?
 - yes no Anticoagulants or blood thinners?
 - yes no Pain pills?
 - yes no Appetite suppressants or diet pills?
 - yes no Sedatives, tranquilizers or sleeping pills?
 - yes no Antidepressants, antipsychotics or nerve pills?
 - yes no Recreational or illegal drugs?
 - yes no Homeopathic or herbal medicines? (List)
 - yes no Other drugs or medications used? (If yes list here)
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MEDICATIONS THAT CAUSE BLEEDING Do you take any of the following on a regular basis: (If yes, please circle item)

- yes no Aspirin or aspirin containing medications?
- yes no Ibuprofen (Motrin, Advil & Nurpin)?
- yes no Ketoprofen (Aleve)?
- yes no Vitamin E? (excluding that in a multivitamin)
- yes no Anti-inflammatories or muscle relaxants?

IMPORTANT MEDICAL CONDITIONS Have you ever had or received treatment for any of the following:

- yes no Hepatitis, liver disease?
- yes no HIV or AIDS?
- yes no Asthma? TB?
- yes no Pulmonary embolus?
- yes no High blood pressure?
- yes no Heart attack, palpitations?
- yes no Congenital heart disease?
- yes no Chest pain?
- yes no Dizziness?
- yes no Pacemaker?
- yes no Artificial heart valve?
- yes no Mitral valve prolapse?
- yes no Fainting?
- yes no Gastroesophageal reflux?
- yes no Chronic fatigue syndrome?
- yes no Psychological or emotional problems?
- yes no Shingles, cold sores, fever blisters or oral herpes?
- yes no Stomach ulcers?
- yes no Chronic or recent cough?
- yes no Phlebitis, blood clots or varicose veins?
- yes no Blood transfusions?
- yes no Adverse or unusual reaction to anesthesia?
- yes no Abnormal healing or poor scar formation?
- yes no Edema, persistent or unusual swelling?
- yes no Venereal disease?
- yes no Anxiety or "panic attacks"?
- yes no Migraines, headaches?
- yes no Anemia or blood disorder?
- yes no Abnormal bleeding?
- yes no Easy bruising?
- yes no Alcoholism?
- yes no Drug addiction?
- yes no Kidney failure?
- yes no Glaucoma?
- yes no Stiff neck?
- yes no Back problems?
- yes no Artificial joint?
- yes no Diabetes?
- yes no Thyroid problem or Graves disease?
- yes no Chronic head pain?
- yes no Seizures?
- yes no Stroke?
- yes no Bell's palsy or neurological problems?
- yes no Autoimmune disease? Lupus?
- yes no Depression?
- yes no Personality disorder?
- yes no Bipolar or manic depressive illness?
- yes no Currently in therapy or counseling?
- yes no Severe allergy attack?
- yes no X-Ray treatments or radiation therapy?
- yes no Sleep apnea?
- yes no Sleep disorder?
- yes no Body dimorphic disorder?

IMPORTANT MEDICAL CONDITIONS (Continued):

yes no Eating disorder?
 yes no Other medical condition (If yes, list here)

ANESTHESIA

yes no Do you have a blood relative who had anesthesia complications of any kind?

SMOKING

yes no Do you currently smoke or have you smoked in the past? If yes:

Average number of packs smoked per day _____
Approximate number of total years smoking _____
If quit, number of years quit _____

DENTAL

yes no Do you have dentures, veneers, capped teeth?

PREGNANCY (Women)

yes no Are you sexually active?
 yes no Are you currently using birth control?
 yes no Are you pregnant?

Please list all *plastic surgery* procedures you have EVER UNDERGONE:

Please list all other surgical procedures you have undergone:

I certify that the above is true, correct and complete. I am aware and accept that withholding information about my medical history could result in serious injury to me or harm to those involved in my care.

Patient Signature/Date

Witness Signature/Date