PLASTIC SURGERY
ENVY Aesthetic Center

Lyle D. Weeks M.D.

Health Questionnaire

DATE:__________________

PATIENT NAME:____

DOB:_______________ Age:________ Smoker: Yes[ ] No[ ]

PROCEDURE(S) INTRESTED IN:____

ALLERGIC TO:____

CURRENT MEDICATIONS:____

HISTORY OF PROBLEMS WITH ANESTHESIA?____

PAST SURGERIES:____

____

DO YOU HAVE ANY PROBLEMS WITH:	**IF "YES" PLEASE DATE:**		
HEART / HEART MURMER	YES	NO	____________________
DIABETES	YES	NO	____________________
BLOOD PRESSURE (HIGH / LOW)	YES	NO	____________________
ASTHMA	YES	NO	____________________
STROKE	YES	NO	____________________
KIDNEY PROBLEMS	YES	NO	____________________
LUNG DISEASE	YES	NO	____________________
CANCER	YES	NO	____________________
EYE PROBLEMS	YES	NO	____________________
HIV POSITIVE / AIDS	YES	NO	____________________
BLEEDING PROBLEMS	YES	NO	____________________
PREGNANT	YES	NO	____________________
ILLEGAL DRUG USE	YES	NO	____________________
HAVE YOU HAD A MAMMOGRAM?	YES	NO	____________________
HISTORY, BREAST PROBLEMS / PROCEDURES:	YES	NO	____________________

FAMILY/PERSONAL HISTORY OF BLOOD CLOT FORMATION OF EXTREMITIES:____________________

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ANY OTHER MEDICAL PROBLEMS NOT MENTIONED:____

____

HEIGHT:__________ WEIGHT:_________

FAMILY DOCTOR / SPECIALIST TREATING YOU?____

FOR WHAT CONDITION:____

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