The Stern Center for Aesthetic Surgery, P.C.

PRE-HISTORY FORM **PATIENT NAME**_____

1. State in your own words the major reason(s) for coming to The Stern Center for Aesthetic Surgery.

_____

_____

_____

2. Please list all medicines that you use:

Medication_____Dose_____Frequency_____Reason_____

_____

_____

_____

_____

_____

3. Family History: Please indicate the health or cause of death of members of your family as best you can:

	AGE IF LIVING	AGE AT DEATH	INDICATE ANY SERIOUS DISEASES	CAUSE OF DEATH
Mother				
Father				
Brothers				
Sisters				
Children				
Spouse				

_____

4. Please give details of any - _____ Approximate date_____ Surgeon_ _____ Hospital_____

Operations -

_____

_____

_____

_____

Serious Injuries –

_____

PLEASE CONTINUE ON BACK >>>>>>>>>>

Continued from other side:

5. Please indicate by checking "yes" or "no" if you have had significant problems in the below areas. Please comment on special problems:

YES	NO	Nature of Problem	COMMENT and give approximate date
		Recent weight loss / gain	
		Trouble with vision	
		Trouble with hearing	
		Allergies - - Hayfever / Food / Latex	
		Allergic Reaction to Medications? Which Ones?	
		Thyroid (goiter)	
		Diabetes	
		Skin	
		Anemia or Abnormal Bleeding	
		Circulation	
		Heart / Blood Pressure	
		Chest Pain / Heart Attack / Stroke	
		Lungs (pneumonia, asthma, TB etc)	
		Shortness of breath – cough Pleurisy, Wheezing	
		Liver disease, Gallbladder disease or Jaundice	
		Stomach trouble – Ulcers, Indigestion, change in bowel habits, Constipation , Diarrhea, Reflux	
		Abdominal pain	
		Kidney disease or stones / Bladder Problems	
		Joint pain or stiffness	
		Do you smoke? How much?	
		Do you drink alcoholic beverages? How much?	
		Recreational Drugs?	
		Psychiatric / Depression	
		Fainting or Convulsions / Headaches	
		HIV / HEP C	
		Other Illness - Problem - Other Infectious Diseases	

6. Please feel free to attach any other recorded information which you feel will be of importance to the doctor in evaluating your health problems.

