AVIVA
PLASTIC SURGERY & AESTHETICS

PATIENT MEDICAL HISTORY FORM

NAME: _____ DATE OF BIRTH: _____

PREFERRED NAME: _____ AGE: _____

SEX: ❑ F ❑ M HEIGHT: _____ WEIGHT: _____ RACE: _____

ADDRESS (STREET AND STATE): _____ ZIP: _____

TELEPHONE: _____ EMAIL: _____

EMERGENCY CONTACT NAME & NUMBER: _____

PREFERRED PHARMACY: _____

PHARMACY TELEPHONE or ADDRESS: _____

How did you hear about Aviva Plastic Surgery & Aesthetics?

_____

What is your primary concern or treatment goal?

_____

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?
Are you allergic to: ❑ Milk protein ❑ Egg/Egg protein ❑ Shellfish/ Iodine ❑Adhesive ❑ Latex

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

PAST MEDICAL HISTORY

Do you now or have you ever had:

❑ Diabetes	❑ Heart murmur	❑ Crohn's disease
❑ High blood pressure	❑ Pneumonia	❑ Colitis
❑ High cholesterol	❑ Pulmonary embolism	❑ Anemia
❑ Hypothyroidism	❑ Asthma	❑ Jaundice
❑ Goiter	❑ Emphysema	❑ Hepatitis
❑ Cancer (type) _____	❑ Stroke	❑ Stomach or peptic ulcer
❑ Leukemia	❑ Epilepsy (seizures)	❑ Rheumatic fever
❑ Psoriasis	❑ Cataracts	❑ Tuberculosis
❑ Angina	❑ Kidney disease	❑ HIV/AIDS

❑ Heart problems ❑ Kidney stones

Other medical conditions (please list):

PAST SURGICAL HISTORY	
Please list the surgical procedures you have had:	
Surgery Type:	**Year:**
1.	
2.	
3.	
4.	
5.	
6.	

PERSONAL HISTORY

Were there problems with your birth? (specify)

Where were your born & raised?

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

What is your current or past occupation?

Hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Are you currently working? : ❑ Yes ❑ No

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability & how long?_____

Have you ever had legal problems? (specify)

Religion:

Are you a smoker, or do you use nicotine products/ patches/ vaping?

How much alcohol do you consume on average?

Do you use non-prescription drugs? What kind?

Are you physically active? If so, what type of exercises do you do? How often?

Have you ever been under the care of a Psychiatrist or Psychologist?

Have you been involved in a medical malpractice suit?

Do you accept that medicine and surgery may have unpredictable outcomes and complications?

FAMILY HISTORY	
IF LIVING	**IF DECEASED**
EXTENDED FAMILY MEDICAL PROBLEMS PAST & PRESENT: Maternal Relatives:	
Paternal Relatives:	

In the past month, have you had any of the following problems?

GENERAL	**NERVOUS SYSTEM**	**PSYCHIATRIC**
❑ Weight gain; how much_____	❑ Headaches	❑ Depression

❑ Weight loss: how much_____
❑ Fatigue
❑ Weakness
❑ Fever
❑ Night sweats

MUSCLE/JOINTS/BONES
❑ Numbness
❑ Joint pain
❑ Muscle weakness
❑ Joint swelling
Where?

EARS
❑ Ringing in ears
❑ Loss of hearing

EYES
❑ Pain
❑ Redness
❑ Loss of vision
❑ Double or blurred vision
❑ Dryness

THROAT
❑ Frequent sore throats
❑ Hoarseness
❑ Difficulty in swallowing
❑ Pain in jaw

HEART AND LUNGS
❑ Chest pain
❑ Palpitations
❑ Shortness of breath
❑ Fainting
❑ Swollen legs or feet
❑ Cough

❑ Dizziness
❑ Fainting or loss of consciousness
❑ Numbness or tingling
❑ Memory loss

STOMACH AND INTESTINES
❑ Nausea
❑ Heartburn
❑ Stomach pain
❑ Vomiting
❑ Yellow jaundice
❑ Increasing constipation
❑ Persistent diarrhea
❑ Blood in stools
❑ Black stools

SKIN
❑ Redness
❑ Rash
❑ Nodules/bumps
❑ Hair loss
❑ Color changes of hands or feet

BLOOD
❑ Anemia
❑ Clots

KIDNEY/URINE/BLADDER
❑ Frequent or painful urination
❑ Blood in urine

Women Only:
❑ Abnormal Pap smear
❑ Irregular periods
❑ Bleeding between periods
❑ PMS

❑ Excessive worries
❑ Difficulty falling asleep
❑ Difficulty staying asleep
❑ Difficulties with sexual arousal
❑ Poor appetite
❑ Food cravings
❑ Frequent crying
❑ Sensitivity
❑ Thoughts of suicide / attempts
❑ Stress
❑ Irritability
❑ Poor concentration
❑ Racing thoughts
❑ Hallucinations
❑ Rapid speech
❑ Guilty thoughts
❑ Paranoia
❑ Mood swings
❑ Anxiety
❑ Risky behavior

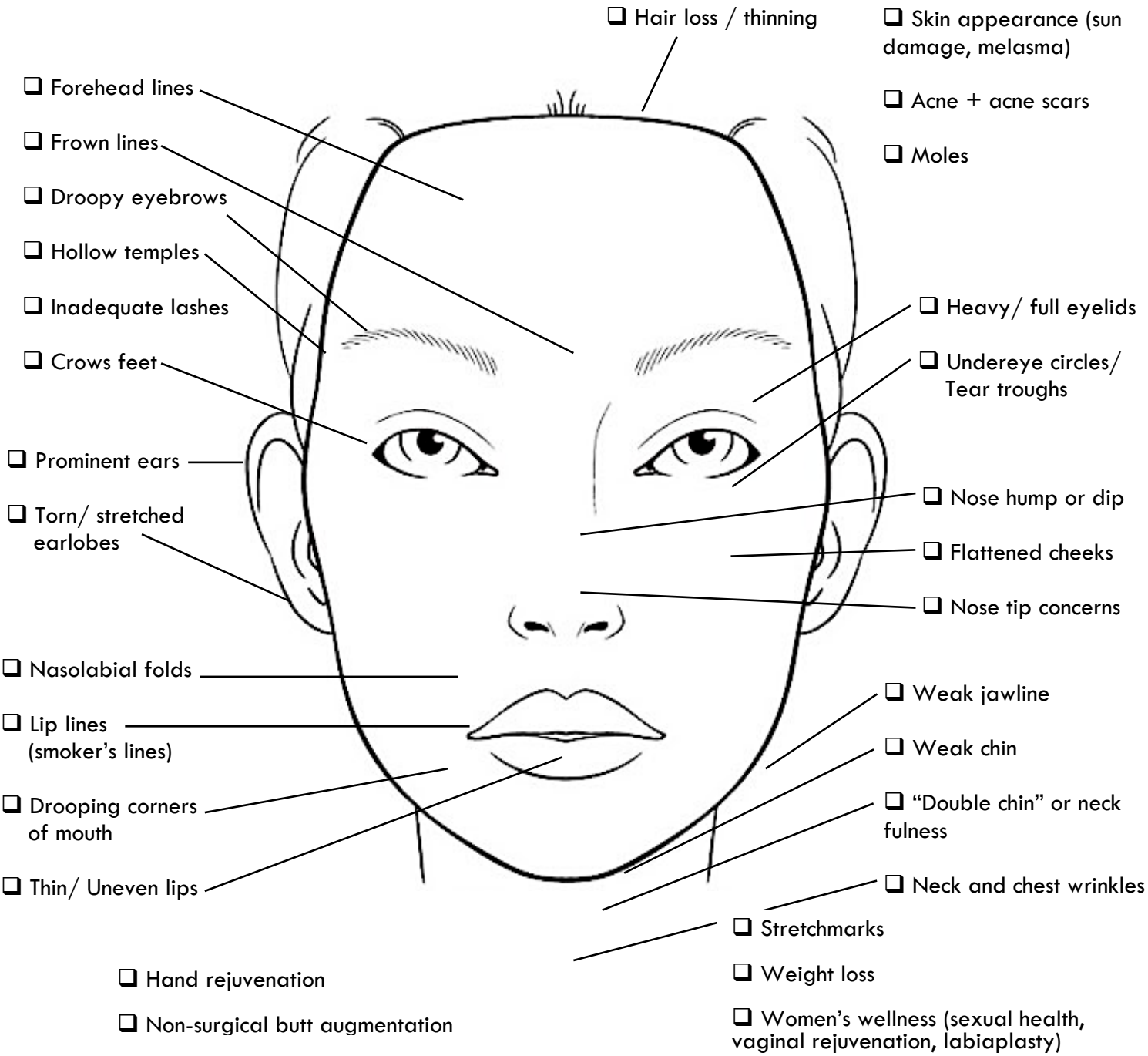
OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:
Age of first period: _____
Pregnancies: _____ # Children: _____
Have you reached menopause? At what age?_____
Do you have regular periods?
When was your last OBGYN visit? _____
When was your most recent PAP smear? _____
When was your most recent menstrual period? _____
Have you had any pelvic, vaginal, or abdominal surgery?
Do you have any implantable devices (such as a pacemaker or defibrillator)?
Do you have any metal implants? Have you ever had skin cancer?
Do you have active skin disorders (such as psoriasis or eczema)?
Have you taken the medication Accutane within the last 6 months?
Do you have a history of bleeding disorders?
Do you have any tattoos or permanent makeup?
Do you have any problems with your immune system?
Do you have any skin scar disorders (such as keloids or problems with wound healing)?
Are you sexually active?
Are you currently pregnant? Are you currently breastfeeding?
What method of birth control do you currently use?
❑ None ❑ Condoms ❑ Pill ❑ Patch ❑ Arm implant ❑ Vaginal ring ❑ IUD ❑ Other
Have you ever had the following STDS (sexually transmitted diseases)?
❑ HIV ❑ HPV ❑ Syphilis ❑ Hepatitis B ❑ Hepatitis C ❑ Other

PATIENT SELF-ASSESSMENT

NAME: _____ DATE: _____

Select which areas of the face concern you on the diagram below.
By sharing how you see yourself, we can best understand your aesthetic goals and tailor a treatment plan specific for you.



Your Top 3 Areas of Concern:
1.
2.
3.

Your Treatment Plan Timeline (Office Use Only)