



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: <input type="checkbox"/> No <input type="checkbox"/> Yes To what?		
Are you allergic to: <input type="checkbox"/> Milk protein <input type="checkbox"/> Egg/Egg protein <input type="checkbox"/> Shellfish/ Iodine <input type="checkbox"/> Adhesive <input type="checkbox"/> 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:		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Crohn's disease
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Colitis
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Pulmonary embolism	<input type="checkbox"/> Anemia
<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Asthma	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Goiter	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Cancer (type) _____	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stomach or peptic ulcer
<input type="checkbox"/> Leukemia	<input type="checkbox"/> Epilepsy (seizures)	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Angina	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> HIV/AIDS

IMPORTANT note: When you have completed this form, please send the PDF version to hello@avivaplasticsurgery.com. Additionally, please send any clinically relevant photos or documents.

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 you 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

Weight gain; how much _____

NERVOUS SYSTEM

Headaches

PSYCHIATRIC

Depression

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- 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

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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.

Hair loss / thinning

Skin appearance (sun damage, melasma)

Acne + acne scars

Moles

Forehead lines

Frown lines

Droopy eyebrows

Hollow temples

Inadequate lashes

Crows feet

Heavy/ full eyelids

Undereye circles/ Tear troughs

Prominent ears

Torn/ stretched earlobes

Nose hump or dip

Flattened cheeks

Nose tip concerns

Nasolabial folds

Lip lines (smoker's lines)

Drooping corners of mouth

Thin/ Uneven lips

Weak jawline

Weak chin

"Double chin" or neck fullness

Neck and chest wrinkles

Stretchmarks

Weight loss

Women's wellness (sexual health, vaginal rejuvenation, labiaplasty)

Hand rejuvenation

Non-surgical butt augmentation

Your Top 3 Areas of Concern:

- 1.
- 2.
- 3.

Your Treatment Plan Timeline (Office Use Only)