Yoon Plastic Surgery, MD, LLC

Plastic, Reconstructive & Cosmetic Surgery

HEALTH HISTORY

Patient Name:_____ **DOB:**_____ **AGE:**_____

Please answer all of the questions as accurately as possible. If you have questions, please ask for assistance.

Smoking (type & amount per day)_____
If former smoker, date quit _____
Any other drugs _____

Alcohol (type and amount per week)_____
Weight_____ Height_____
Do you regularly exercise?_____

Drug Allergies and Reaction:

_____

List previous Surgeries (and dates) and Medical History:

_____

_____

_____

List any medications you are taking, *including non-prescription drugs, vitamins, and herbals, pain relievers, etc*:

_____

_____

Family History:

Has any blood relative ever had the following?

Breast Cancer	no	yes	High blood pressure	no	yes	Blood Clots	no	yes
Melanoma	no	yes	Heart Disease	no	yes	Depression	no	yes
Stroke	no	yes	Diabetes	no	yes	Any other Cancer	no	yes

Past Medical History:

Have you ever had the following?

Heart disease	no	yes	Cancer	no	yes	Stomach Ulcer	no	yes
Arthritis	no	yes	Glaucoma	no	yes	Kidney disease	no	yes
Rheumatic Fever	no	yes	Asthma	no	yes	Thyroid Disease	no	yes
Anemia	no	yes	AIDS or HIV	no	yes	Bleeding tendency	no	yes
Depression	no	yes	Stroke	no	yes	Mitral Valve Prolapse	no	yes
Diabetes	no	yes	Hepatitis	no	yes	High Blood Pressure	no	yes
Blood Clots	no	yes	Surgeries	no	yes	Problem with Anesthesia	no	yes

Review of Systems

Do you have now or have you had within the past year:

Weight change	no	yes	Breast lump	no	yes	Seizures	no	yes
Dry eyes	no	yes	Skin rash	no	yes	Swollen feet or ankles	no	yes
Chronic cough	no	yes	Easy bruising	no	yes	Swollen lymph nodes	no	yes
Chest pain	no	yes	Depression	no	yes	Joint pain/muscle pain	no	yes
Chronic diarrhea	no	yes	Jaundice	no	yes	Headaches	no	yes

Women only:

Date of last mammogram_____ Do you do regular breast self-examinations?_____
Number or pregnancies_____ Age period began_____
Did you breast feed?_____ Date of last period_____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X_____ _____

Signature of patient or parent (if patient is minor) Date