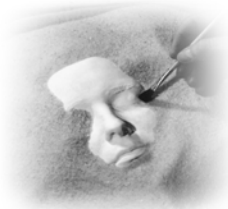

Manuel M. Peña, M.D., P.A.
6370 Pine Ridge Road, Suite 101
Naples, Florida 34119
(239) 348-7362

Health History

Name: ____ **Date:**______________________________
(please print)

What is the purpose of this consultation? What would you like to correct and what are your aesthetic goals?

____

____

Yes No **Have you ever consulted a plastic surgeon before?**
Yes No **Have you ever had plastic surgery before?** (Please describe, including dates)

____

Yes No **If you have had plastic surgery, are you satisfied with the results?**

Please list any surgeries you have had within the past ten (10) years.

____

____

Have you had any of the following? (Please circle any procedures you have had.)

Collagen	Accutane	Skin Cancer
Botox	Chemical Peel	Restylane
Dermabrasion	Radiance	Radiation Treatment

Please list any additional procedures you have had such as stress test/cardiac catherization.

____

Yes No **Have you had any problems with anesthesia in the past?** Has anyone in your family?____

Yes No **During any previous anesthesia, have you or any member of your family had anything unusual happen such as significant allergic reaction or difficulty emerging or coming off anesthesia?** If yes, please describe the situation. ___________

____

Please describe reasons for any other hospital admission within the past ten (10) years.

____

Yes No **Do you heal well?**

Yes No **Do you bruise easily?**

Yes No **Do you scar badly?**

Yes No **Have you ever taken cortisone, predisone, or any other cortisone-type of steroid medication?**

What medication do you take now (including vitamins, aspirin, etc.)? Please do not omit anything as medications used during and after surgery may interact adversely.

Medication	Dosage	Frequency	Purpose

Yes No **Have you ever had a bad reaction or an allergic reaction to any medication or to adhesive tape?** (Please describe reaction from medication.)

____

Yes No **Do you smoke?** For how long? ________ years. How many? _________ per day. When did you quit? ____________

Please describe your alcohol consumption. (daily, weekly, monthly?) (quantity?)

____

Yes No **Do you, or in the past, have you had, frequent regular prolonged direct exposure of your skin to the sun or sun-tanning devices?**

Yes No **Are you allergic to any skin medications, lotions or creams?** If yes, please list what medicines, lotions, or creams that you currently use on your skin.

____

Have you ever been diagnosed with the following: (please indicate any of the following by circling *yes* or *no* and then circle the specific diagnosis.)

Yes No Angina, coronary artery disease, or heart valve problem?

Yes No Asthma, emphysema, chronic bronchitis, lung cancer, or any other serious pulmonary problems which may contribute to shortness or breath?

Yes No History of pulmonary emboli or blood clots from your legs to your lungs?

Yes No Kidney disease of any kind including kidney failure, kidney stones or prostate enlargement?

Yes No Diabetes requiring medication or insulin? What dose?

Yes No Arthritis of any type rheumatoid or osteoarthritis, degenerative joint disease?

Yes No Lupod, sarcoid, or any other autoimmune disorder?

Yes No History of tuberculosis, hepatitis, or HIV infection?

Yes No Circulation problems such as blocked arteries in the legs causing leg pain when you walk, blood clots in your legs such as a deep venous thrombosis, or history of varicose veins?

Yes No Easy or free bleeding, history of leukemia, or lymphoma? Have you been told that you are anemic in the past?

Yes No Chronic gastrointestinal problems such as ulcers, diarrhea, constipation, or tumors (benign or malignant) of the GI tract?

Yes No History of seizures or other neurological disorders such as headaches, including migraines and tension headaches or dizziness?

Yes No Seasonal allergies or history of contact dermatitis?

Yes No Visual impairment such as glaucoma or cataracts? Have you had laser treatments to the eyes? Do you have dry eye syndrome?

Yes No Do you have allergies to eye drops, eye ointment, or eye make-up?

Yes No Do you wear dentures?

If you have answered "Yes" to any of the above, please explain:______________________________
____
____

Yes No **Are you currently under the care of or do you have a physician you call or visit for medical problems?**

Name:____

Address:____

Phone:____

Yes No **May we consult, if necessary, with your physician?**

Thank you for completing this health history form. All information will be kept confidential and as part of your medical records.

Your Pharmacy____________________________________ Phone:______________________________

I, ______________________, state that the above information is true and correct: (please sign below)
Patient's Name (print)

____ _____________________________________
Patient's Signature Date