RITACCA COSMETIC SURGERY & MEDSPA

Medical History Questionnaire

Name: _____ Date: _____

Please circle (P) if you, the *Patient* or (F) if a *Family* member has experienced any of the following:

P F AIDS / HIV
P F Anesthesia Allergy
P F Anemia
P F Angina
P F Arthritis
P F Artificial Heart Valves of Joints
P F Asthma / Emphysema
P F Back Problems
P F Bleeding Disorders
P F Cancer
P F Chemical Dependency
P F Chest Pain
P F Chronic Diarrhea
P F Chronic / Frequent Cough
P F Circulatory Problems
P F Dentures / Bridges / Loose Teeth
P F Diabetes
P F Ear / Hearing Problems
P F Easy bruising
P F Epilepsy
P F Eye Problems
P F Fainting
P F Foot Problems
P F Ulcers
P F Foot / Leg Cramps
P F Forgetfulness
P F Gout
P F Prescribed Vit.A (Retin A, Renova)
P F High Blood Pressure
P F Rheumatoid Arthritis
P F Collagen Vascular or Autoimmune
P F Dry Eyes or Blepharitis

P F Kidney Problems
P F Liver Disease
P F Low Blood Pressure
P F Lupus
P F Memory Loss
P F Nervousness
P F Psychiatric Care
P F Radiation Treatment
P F Rashes /Eczema
P F Respiratory Disease
P F Rheumatic Fever
P F Seizure Disorder
P F Shortness of Breath
P F Sinus Problem
P F Skin Cancer
P F Stroke
P F Swelling in Hands or Feet
P F Swollen Glands in Neck
P F Throat Pain
P F Tired Feet
P F Tuberculosis
P F Headaches

P F Heart Disease
P F Varicose Veins
P F Venereal Disease
P F Weight Loss / Gain
P F Rosacea
P F Cold Sores
P F Lupus or Sjorgren's
P F Psychiatric / Antidepressants
P F History of Ocular disease or Surgery

- **Do you Take Accutane or Amiodarone ? Y / N are you Pregnant or Nursing? Y / N**

List any medical problems or diseases you are being treated for or have been treated for in the past._____

_____

Past Surgeries: _____

Past Hospitalizations: _____

Other Doctors Caring For You: _____

Medications You're Taking: _____

Pharmacy Name and Telephone: _____

How often do you exercise? _____

Current Height: _____ Current Weight: _____

Do you smoke? Y / N # of years? _____ # of packs / day _____

Do you drink alcoholic beverages? Y / N Amount consumed / week

Are you ***Allergic to:***

Y N Adhesive Tape
Y N Aspirin
Y N Codeine
Y N Latex
Y N Iodine Seafood
Y N Novocaine
Y N Penicillin
Y N Prior Anesthetic Problems
Y N Sulfa Drugs
Y N Demerol

Please list any other allergies _____

Signature: _____ Date _____