Jon Paul Trevisani, M.D., F.A.C.S

The Aesthetic Surgery Centre

Patient Health History

Patient name: _____ Date: ___/___/_____
Primary Care Physician: _____ Telephone: (____) _____

Past Health History

Please list previous health problems: _____

_____
_____
_____
_____
_____

Please list any prior surgeries and dates: _____

_____
_____
_____
_____
_____

Please list medications and supplements you are taking: (include herbal supplements, CBD and/or Hemp Oil)

_____
_____
_____
_____
_____

Medication Allergies: _____

_____
_____
_____
_____
_____

Have you ever had a mammogram? No ___ Yes ___ Date: ___/___/_____
Where was your last mammogram done? _____ Telephone (___) _____

Social History

Do you smoke? (please include vaping) No ( ) Yes ( )
If yes, Packs/Day:_____ Years:_____
Have you ever smoked? No ( ) Yes ( )
If yes, How long have you been "smoke free?" _____ days/weeks/months/years
Do you drink alcohol? No ( ) Yes ( )
If yes, how many drinks _____ per day/week/month
Do you use illegal drugs? (This is for your safety during anesthesia.) No ( ) Yes ( )
If yes, What drugs? _____

Health History

Have you ever had general or twilight anesthesia? No ( ) Yes ( )
Have you or anyone in your family had unusual reactions to anesthesia? No ( ) Yes ( )
(muscle weakness, jaundice, breathing problems, unexpected fevers, Malignant Hyperthermia, prolonged time waking up from anesthesia)
Do you or a family member have a history of breast cancer? No ( ) Yes ( )
If yes, who? _____
Do you use a CPAP machine? No ( ) Yes ( )
Do you have a chronic cough? No ( ) Yes ( )
Do you have any breathing problems? No ( ) Yes ( )
Have you had bronchitis, pleurisy or pneumonia? No ( ) Yes ( )
Have you had asthma? No ( ) Yes ( )
Have you had a recent cold? No ( ) Yes ( )
Have you ever had an abnormal chest x-ray? No ( ) Yes ( )

Do you have problems with motion sickness?	No ( )	Yes ( )
Do you have any bleeding tendencies?	No ( )	Yes ( )
Do you take blood thinners?	No ( )	Yes ( )
Have you or anyone in your family had blood clots?	No ( )	Yes ( )
Have you ever had thrombophlebitis or do your ankles swell?	No ( )	Yes ( )
Have you ever been anemic?	No ( )	Yes ( )
Have you ever had a heart attack or chest pain related to your heart?	No ( )	Yes ( )
Have you had cardiac stents inserted?	No ( )	Yes ( )
Do you have a heart murmur or irregular beat?	No ( )	Yes ( )
Have you ever had high blood pressure?	No ( )	Yes ( )
Do you ever wake up at night short of breath?	No ( )	Yes ( )
Do you have diabetes?	No ( )	Yes ( )
If yes, do you take insulin/use an insulin pump? (please circle)	No ( )	Yes ( )
Have you ever had a thyroid problem?	No ( )	Yes ( )
Have you ever had a stroke?	No ( )	Yes ( )
Have you ever had epilepsy, seizures or fainting spells?	No ( )	Yes ( )
Do you have frequent headaches or migraines?	No ( )	Yes ( )
Have you ever had eye problems or dry eye syndrome?	No ( )	Yes ( )
Do you have a family history of glaucoma?	No ( )	Yes ( )
Do you wear contact lenses?	No ( )	Yes ( )
Do you have chronic bladder problems or kidney disease?	No ( )	Yes ( )
Have you passed bloody urine?	No ( )	Yes ( )
Have you ever been jaundiced?	No ( )	Yes ( )
Have you ever had hepatitis?	No ( )	Yes ( )
Do you have any history of hearing loss?	No ( )	Yes ( )
Have you ever had a broken nose?	No ( )	Yes ( )
Do you have chipped, loose or capped teeth, dentures or braces?	No ( )	Yes ( )
Do you have any sores in your mouth that do not heal?	No ( )	Yes ( )
Are you prone to fever blisters?	No ( )	Yes ( )
Do you have any hoarseness or trouble swallowing?	No ( )	Yes ( )
Do you have any lumps in your neck?	No ( )	Yes ( )
Do you have stomach, bowel or gallbladder problems?	No ( )	Yes ( )
Have you ever had bloody bowel movements?	No ( )	Yes ( )
Do you use aspirin or other over the counter drugs?	No ( )	Yes ( )
Do you have any arm or leg numbness or weakness?	No ( )	Yes ( )
Do you have any physical disabilities or orthopedic problems?	No ( )	Yes ( )
Have you ever received radiation therapy?	No ( )	Yes ( )
Have you ever had psychiatric counseling?	No ( )	Yes ( )
Do you have any reason to believe that you have been exposed to the AIDS virus?	No ( )	Yes ( )
Is there any reason to believe that you are pregnant?	No ( )	Yes ( )

Height: _____ Weight: _____

I attest that the above information that I have provided is complete and accurate.

Patient Signature: _____

Physician Signature: _____