DR. LEE B. DANIEL
AESTHETIC PLASTIC SURGERY • THE SPA SIDE

HEALTH HISTORY FORM

*(Please fill out form with **BLACK** Ink)*

Name: ____ Date: _________________________

Are you currently under the care of a physician? Yes | No
Name of Physician: ________________________________
Date of Last EKG: _________________________________
Do you have any allergies to medicine? Yes | No
Please List: ____
____
____
____
Are you allergic to Latex? Yes | No
Are you allergic to Tape? Yes | No

List any Surgeries (including cosmetic) you've had & date:
____
____
____
____

List all Medications you are currently taking, include Non-Prescription, Vitamins, Herbals & Supplements:
____
____
____
____
____

Have you ever consulted a psychiatrist or psychologist or been prescribed medication by them? Yes | No
If yes, explain and include medications prescribed:
____
____
____

Height: ________ | Weight: ________ | BMI: _______

Do you smoke or use tobacco? Yes | No
Daily Amount: _________ | Weekly: _________
Do you drink alcoholic beverages? Yes | No
Daily Amount: _________ | Weekly: _________
Have you ever been addicted to drugs or alcohol? Yes | No
Explain: ____
____
____

Do you wear contact lenses? Yes | No
Do you bleed easily from cuts or surgery? Yes | No
Have you ever had problems with anesthetic? Yes | No
Have you ever tested positive for HIV? Yes | No
Have you ever taken **Accutane**? Yes | No
Date last taken: ___________________

For Women:
Are you pregnant? Yes | No
Are you lactating? Yes | No
YOU CANNOT HAVE SURGERY IF YOU ARE PREGNANT

Number of Pregnancies: ______ | Deliveries: ______
Date of last Mammogram: _________________________

DO YOU PRESENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING:

Y N Abnormal Bleeding
Y N AIDS
Y N Anemia
Y N Arthritis
Y N Artificial Valves
Y N Asthma
Y N Cancer
Y N Chemotherapy
Y N Chest Pains
Y N Cholesterol
Y N Chronic Fatigue Syndrome
Y N Clotting Problems
Y N Cold Sores
Y N Congenital Heart Defect
Y N Depression
Y N Diabetes
Y N Difficulty Breathing
Y N DVT
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Heart Problems
Y N Hemophilia
Y N Hepatitis
Y N Herpes
Y N High Blood Pressure
Y N HIV
Y N Irregular Heart Beat
Y N Kidney Problems
Y N Liver Problems
Y N Low Blood Pressure
Y N Lupus
Y N Mental Illness
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Persistent Cough
Y N Polycystic Ovaries
Y N Pulmonary Embolism
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Seizures
Y N Sinus Problems
Y N Sleep Apnea
Y N Stroke
Y N Swollen Ankles
Y N Thyroid Problems
Y N Tonsillitis
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Any additional information: ____
____
____

I affirm that the information I have given is correct to the best of my knowledge, it will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status.

____ ________________________

Patient Signature ***Date***