

Dr. Abdel K. Fustok

Medical History

DATE: _____

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In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent. **PLEASE PRINT CLEARLY**  
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Patient's Name: _____ D.O.B: _____

Age: _____ Height: _____ Weight: _____ Email: _____

Procedure(s) of interest: Abdominal, Breast Reduction, Breast Augmentation, Liposuction, Other

If seeing doctor for a breast reduction, please give BRA size _____ Did your Breast Feed: _____

List any discomfort associated with procedure(s) of interest: (see list attached) _____

Have you seen a physician with regards to these symptoms? (circle one) YES NO

If Yes, please fill out the Medical Release Form for us to attain your medical records.

If YES, what treatment(s) or medication(s) were prescribed: _____

Do you smoke? (circle one) YES NO > Started/Stopped _____ A pack lasts _____

Do you drink alcohol? (circle one) YES NO > Daily Occasionally Weekly Rarely

Have you ever had a blood transfusion? (circle one) YES NO

Have you been tested for HIV? (circle one) YES NO

Are you currently taking ANY medication(s), Diet Pills, Vitamins, Herbs? (circle one) YES NO If YES, please list: _____

Frequency: (example – Daily or Twice Daily for 4 months) _____

***Are you allergic to ANY medication(s)? (circle one) YES NO

If YES, please list: _____

***Please list ANY previous surgery: _____

Total Pregnancies: _____

Live births: _____ Miscarriage: _____ Abortion: _____ C-Sections _____

Please list sex and age of each child: _____

Have you or any blood relative had:

HISTORY OF:	YES	NO	WHO
High Blood Pressure			
Diabetes			
Heart Problems			
Anemia/Bleeding			
Breast Cancer/Cancer (any type)			
Stroke			
AIDS			
Psychiatric Illness			
Liver Disease/Hepatitis			
Asthma/Bronchitis/TB			
Thyroid			

PROCEDURE LIST: *(please circle)*

Bilateral Reduction Mammoplasty (breast reduction)
Bilateral Augmentation Mammoplasty (breast enlargement)
Bracheoplasty (Arms)
Rhytidectomy (facelift)
Upper Lid Blepharoplasty (upper lids)
Lower Lid Blepharoplasty (lower lids)
Hand Surgery
Scar Revision
Tattoo Removal
Otoplasty (ear surgery)
Breast Reconstruction
Abdominal Wall Surgery
Liposuction
Mastopexy (breast lift)
Mole or Cyst Removal
Rhinoplasty (nose surgery)
Sclerotherapy (vein treatment)
Endermologie (cellulite treatment)
Restylane (to add fullness to facial features)
Botox (to rid facial lines)
Laser Hair Removal
Microdermabrasion (power peel)

**POSSIBLE SYMPTOMS FOR INSURANCE RELATED PROBLEMS LISTED
ABOVE (please circle:)**

<i>back pain</i>	<i>shoulder pain</i>	<i>problem exercising</i>
<i>neck pain</i>	<i>breast pain</i>	<i>headaches</i>
<i>shoulder indentations</i>	<i>rash/discoloration</i>	<i>sleeping trouble</i>
<i>breast heaviness</i>	<i>numbness</i>	<i>shortness of breath</i>
<i>vision problems</i>	<i>heaviness in lids</i>	<i>breast hardness</i>
<i>shooting pains</i>	<i>acne</i>	<i>burning sensations</i>
<i>keloided scar</i>	<i>depression</i>	<i>fatigue</i>
<i>skin discoloration</i>	<i>open wound</i>	<i>broken nose</i>
<i>posture problems</i>	<i>abdominal pain</i>	<i>constipation</i>
<i>snoring</i>	<i>sagginess</i>	<i>limited mobility</i>
<i>weight loss/gain</i>	<i>stuffiness</i>	<i>sinus infections</i>
<i>allergies</i>	<i>sneezing</i>	<i>nose bleeds</i>
<i>dry mouth</i>	<i>drainage</i>	<i>itching</i>

Medical Patient Questionnaire

QUESTION	YES	NO
Who is your family physician?		
Have you ever been to a dermatologist or cosmetic plastic surgeon? If, YES, who?		
Have you ever had anesthesia for a medical or dental procedure? Any problems?		
Has any member of your family had a serious reaction to anesthesia used for surgery?		
Do you have sinus problems or environmental allergies?		
Do you use any type of inhaler?		
Are you allergic to neosporin or polysporin?		
Are you allergic to adhesive tape?		
Do you consume caffeine: Circle all that apply: coffee, cola, tea, etc?		
Do you use aspirin or ibuprofen products routinely?		
Are you taking birth control pills?		
Could you be pregnant?		
Are you nursing?		
Do you have any type of medical implant(s)?		
Have you ever been treated with one of the following in the past year: Interferon, Radiation, Transfusions, ACTH, Chemotherapy or Cortisone/Prednisone?		
Have you ever had scarlet or rheumatic fever?		
Have you ever had any treatment that included the use of hormones or steroids?		
Do you bleed or bruise easily?		
Are you a slow or poor healer?		
Do you experience Migraine Headaches?		
Have you been diagnosed with or experience Hyperhidrosis?(excessive sweating)		
Do you ever get cold sores or fever blisters?		
Have you ever had severe sunburn?		
Do you use a tanning salon, tanning gels or lotions?(for laser patients only)		
Do you shave or wax any area on your face?(for laser patients only)		
Have you ever had a problem with acne?		
Does your skin scar easily?		
Have you ever used Retin A, Accutane, Renova or Glycolic Acids?		
Have you ever had injections of collagen?		
Have you experienced a significant weight loss or gain in the past year? Circle one and list amount of weight.		

Are you on a special diet?		
Do you exercise regularly? _____ : Days a week _____ : Times spent a day _____ : Type of exercise		
Does exercise cause a shortness of breath?		
Have you had a recent physical examination, If so when? _____ :Date		
Do you have back problems?		
Do you have trouble sleeping?		
Do you wear glasses or contacts?		
Do you have problems with dry eyes?		
Do you feel you have a high level of stress?		
Have you ever had a serious reaction to perfumes, cosmetics or skin care products?		
Is there ANYTHING else you feel is important for us to know?		

If you are currently taking any herbs, vitamins or diet pills please inform us.

Examples: Metabolife, Xenedrine, Metabolite, Ephedrine (Ma Huang), Feverfew, Ginger, Ginkgo(Ginkgo Biloba), Ginseng, Goldenseal, Kava-Kava, Licorice, Valerian, Vitamin E.

LIST ALL HERBS AND VITAMINS:

****Please stop taking all herbs, vitamins and diet pills at least two weeks prior to surgery.**

Signature **Date**