Iorio Plastic Surgery & Medspa

HEALTH HISTORY

Name _____ **Today's Date** _____

Birthdate _____ Age_____ Gender _____ Weight _____ Height _____

MEDICAL HISTORY

Eyes □ Cataracts □ Dry Eyes □ Glaucoma

Ears / Nose / Throat □ Torn Earlobe □ Ear Malformation □ Broken Nose □ Tonsillectomy

Cardiovascular □ Heart Murmur □ Irregular Heartbeat □ Mitral Valve Prolapse □ Heart Attack
□ High Blood Pressure □ High Cholesterol □ Deep Vein Thrombosis
□ Pulmonary Embolism □ Varicose Veins □ Spider Veins

Respiratory □ Asthma □ Emphysema □ COPD □ Apnea/Use CPAP □ Tuberculosis □ Cancer, Lung

Gastrointestinal □ Ulcers □ Heart Burn / Reflux / GERD □ Hernia □ Hepatitis □ Liver Disease

Genitourinary □ Kidney Disease □ Cancer, Ovarian □ Cancer, Prostrate

Neurologic □ Seizure □ Stroke □ Neuropathy □ Fibromyalgia

Psychiatric □ Anxiety □ Depression □ Alcoholism □ Bulimia □ Anorexia □ Drug Addiction
□ Addiction Recovery Program

Endocrine □ Diabetes □ Thyroid Problem

Immunologic □ Arthritis □ HIV/AID □ MRSA □ Other Autoimmune Disorder: _____

Hematologic / Lymphatic □ Anemia □ Bruising / Bleeding Problem □ Blood Transfusion

Breast □ Abnormal Mammogram □ Nipple Discharge □ Breast Lump □ Breast Cancer

Skin □ Basal Cell Carcinoma □ Squamous Cell Carcinoma □ Melanoma □ Actinic Keratosis
□ Keloid Scars □ Scarring Problem □ Dermatitis □ Eczema □ Use of Accutane
□ Cold Sore □ Skin Numbness □ Excessive Sweating □ Tattoo

Other: _____

SURGICAL HISTORY

Year	Type of Surgery	Complications (Surgical or Anesthesia)

METAL IMPLANTS □ NONE

□ Pacemaker □ Defibrillator □ Neurostimulator □ Metal IUD □ Surgical Clip
□ Drug Pump □ Cochlear Implant □ Plates & Screws □ Tissue Expander □ Other Metal Implant

FAMILY HISTORY

	Relationship			Relationship
Cancer (include type)			Heart Disease	
Diabetes			High Blood Pressure	
			Other	

Name: _____

ALLERGIES: List medications, food, and products (ex: penicillin, nuts, latex, etc.) □ **NO ALLERGIES**

Allergen	Reaction (itching, rash)

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MEDICATIONS Include birth control, over-the-counter (OTC) medications, multi-vitamins, and supplements

Drug	**Dosage**	**How often?** (once a day, etc.)	**Form** (tablet, capsule, liquid, injection, etc.)	**Type** (Rx, OTC, Vitamin, Supplement)	**Prescribed by**:

HEALTH HABITS

	How often?	Amount			How often?	Amount
Caffeine	Never, Occasional, Daily			Tobacco	Never, Occasional, Daily	
Alcohol	Never, Occasional, Daily			Recreational Drugs	Never, Occasional, Daily	

FEMALE QUESTIONS

Do you have regular periods?	**Y N**		# of pregnancies	
Are you pregnant or lactating	**Y N**		# of deliveries	
Did you hyperpigment/mask when pregnant?	**Y N**		# of vaginal deliveries	
Have you gone through menopause?	**Y N**		# of c-section deliveries	

REVIEW OF SYSTEMS ***Please check all SYMPTOMS that you are currently experiencing.***

Constitutional □ Weight loss □ Fever □ Chills □ Night Sweats □ Fatigue

Eyes □ Blurry vision □ Eye Pain □ Discharge □ Dry Eyes □ Decreased vision

Ears / Nose / Throat □ Ringing in ears □ Hearing loss □ Bloody nose □ Sinusitis □ Sore Throat

Respiratory □ Shortness of Breath □ Chronic Cough □ Cough blood □ Wheezing

Cardiovascular □ Chest Pain □ Palpations □ Edema □ Fainting

Gastrointestinal □ Nausea □ Vomiting □ Diarrhea □ Vomit blood □ Fecal blood □ Dark fecal

Genitourinary □ Vaginal Infection □ Blood in urine □ Difficult urination □ Hesitancy □ Incontinence □ UTI's

Musculoskeletal □ Joint pain □ Muscle pain □ Muscle weakness □ Joint swelling □ NSAID use

Skin □ Rash □ Itchiness □ Sores □ Nail changes □ Skin thickening □ Lesions

Neurologic □ Migraines □ Numbness □ Loss of Muscle Control □ Tremors □ Dizziness

Endocrine □ Excess thirst □ Excess urination □ Cold Intolerance □ Heat Intolerance □ Enlarged Thyroid

Psychiatric □ Anxiety □ Depression □ Alcohol abuse □ Cannot sleep

Hematologic / Lymphatic □ Bruises easily □ Bleeds easily □ Swollen glands

Allergic / Immunologic □ Allergic Rhinitis □ Hay Fever □ Hives □ NONE OF THE ABOVE