Downsize Liposuction

CENTER OF HOUSTON

PATIENT MEDICAL HISTORY FORM

Last Name:_____First Name:_____Sex: F M
Address:_____City:_____State____Zip:_____
Home Phone_____Cellular_____Email_____
Birthdate_____Age:_____Height_____Weight_____Waist_____Pant Size____Shirt Size___
Person to Contact in Case of Emergency and Telephone Number_____
Family Physician:_____Phone:_____
Occupation:_____
Please answer the following by Circling YES or NO:

High Blood Pressure:	YES NO	Skin Disease:	YES NO
Bleeding Disorder:	YES NO	Thyroid Disease:	YES NO
Anemia:	YES NO	Lung Disease:	YES NO
Liver Disease:	YES NO	Tuberculosis:	YES NO
Heart Disease:	YES NO	Hepatitis:	YES NO
Psychiatric illness:	YES NO	Diabetes:	YES NO
HIV:	YES NO	Shortness of Breath:	YES NO
Herpes I or II:	YES NO	Keloid Scarring:	YES NO
Blood Clots:	YES NO	Kidney Disease:	YES NO
History of Seizure:	YES NO	Dizziness or Fainting:	YES NO
Asthma:	YES NO	Vascular Disease:	YES NO

Hernia/Umbilical: I currently have one/have history of having one: YES NO
Have you ever had Liposuction? YES/NO What Area:_____Month/Year_____
Have you had Gastric Bypass, Sleeve, Lapband, or other Weight Loss Surgeries: Y/N Month and Year_____
Have you ever lost over 50lbs? YES/NO How much weight have you lost?_____Month and Year_____
Please list any other medical history the doctor should be aware of:_____
Have you ever had an HIV test? YES/NO If YES then When:_____Results:_____
Have you recently been under the care of a physician for any reason? YES NO
If "YES" please explain:
(for Women)Are you or could you be pregnant? YES/NO Last Menstrual Period: / /
(for Women) Are you breastfeeding: YES/NO
MEDICATION:
Please list medications you currently take, including appetite suppressants, vitamins, herbal supplements, or any homeopathic medication:
Have you taken Accutane or Anticoagulants in the last 6 months? YES NO
Do you have any ALLERGIES and/or SENSITIVITIES? (Please indicate by circling YES or NO):

Penicillin: YES NO Aspirin: YES NO Lidocaine: YES NO Novocaine: YES NO
Sulfa: YES NO Xylocaine: YES NO Codeine: YES NO
Latex: YES NO Shellfish: YES NO Valium: YES NO
Any Other:_____
Cigarette Smoking: YES NO How long since last use and how many?:_____
Alcohol Use: YES NO How much?_____
Do you take Vitamin E: YES NO Drug Use: YES NO
Please list all previous surgeries, as well as cosmetic:_____
_____Date:_____
_____Date:_____
Any complications or problems during or following the above procedure: YES NO
Which body area/areas would you like treated:_____
What are your expectations for liposuction?_____
_____

Signature:_____Date:_____

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