

Iorio Plastic Surgery & CosMedical Center

HEALTH HISTORY

Name _____ Birthdate _____ Age _____

Reason for your visit _____

Medications & Vitamins currently taken _____

Allergies (include foods, medications, substances) _____

Conditions Experienced

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Transfusions |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal Infection |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Psychiatric Care | |

Surgical History

Year _____ Illness/Injury _____ Year _____ Illness/Injury _____
 Year _____ Illness/Injury _____ Year _____ Illness/Injury _____
 Year _____ Illness/Injury _____ Year _____ Illness/Injury _____

Pregnancy History

Number of Pregnancies _____ Number Delivered _____ Type of Delivery: *Vaginal C-Section*
 Complications _____

Family History

Cancer _____
 Diabetes _____
 Heart Disease _____
 High Blood Pressure _____

Health Habits

Caffeine How much per day? _____ Alcohol How much per day? _____
 Tobacco How much per day? _____ Drugs How much per day? _____

I certify that the above information is correct to the best of my knowledge.

Signature _____
Date