NORTH TEXAS COSMETIC SURGERY
Combining Skill and Artistry to Create a Refined and Refreshed New You

Alan M. Greenberg M.D.
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Medical History Questionnaire

Please answer all the questions, check off boxes, and fill in the blanks when indicated. All answered to the questions will be for chart use office records only and will be considered confidential.

Primary Care Physician/Internist:_____ *Tel:*_____
*Address/Location:*_____

Have you had a recent medical evaluation by your Primary Care Physician, Internist, or Cardiologist? □ *Yes* □ *No*
Date/Findings: _____

Are you or have you been under the care of a Cardiologist? *If yes, please provide their information:*
*Cardiologist:*_____ *Tel:*_____
*Address/Location:*_____
*When did you have your last EKG and/or Chest x-ray?*_____

Please list all medications and/or dietary supplements including:
Over the counter medications, aspirin, vitamins and herbal Supplements such as fish oil, saw palmetto, flax seed oil, St. John's Wart (Please include both prescription and non-prescription medications)

_____

_____

Please list all medication and/or environment allergies and describe reaction?

_____

_____

Social History

Do you drink alcoholic beverages? □ *Yes* □ *No*
If yes, about how often _____

Do you smoke: This includes cigarettes, cigars, e-cigarettes, and/or recreational drugs? □ *Yes* □ *No*
If yes, about how often _____

Do you exercise? □ *Yes* □ *No*
If yes, about how often _____

Do you consume a normal diet? □ *Yes* □ *No*
Do you have any dietary restrictions? □ *Yes* □ *No*
If yes, please explain: _____

Female Gynecological History

Have you had any previous deliveries? □ *Yes* □ *No* *If yes, how many?*_____ □*Natural* / □*C-section*

Are you currently pregnant or plan on getting pregnant in the near future? □ *Yes* □ *No*

Are you currently breast feeding, or plan on breast feeding? □ *Yes* □ *No*
If recently pregnant and breast fed, when did you stop? _____

Do you have a personal or family history of a previous breast mass, suspicious biopsy, or cancer?□ *Yes* □ *No*
If yes, please explain: _____

Have you had a recent mammogram in the last year? □ *Yes* □ *No* □ *Normal Findings* □ *Abnormal Findings*

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Personal Current and/or Past History

Have you been hospitalized or had a serious illness? □ *Yes* □ *No*
If yes, please explain: _____

Have you ever required a blood transfusion for a medical condition? □ *Yes* □ *No*
If yes, please explain: _____

Have you had abnormal bleeding or scarring associated with previous extractions, surgery or trauma? □ *Yes* □ *No*
If yes, please explain: _____

Do you have a personal or family history of blood clots in the legs or lungs, or leg swelling? □ *Yes* □ *No*
If yes, please explain: _____

Do you have a Personal History to any of the following? (Please check all that apply)

□ *Asthma or Hay Fever*	□ *Hives, Skin Rash, or Fever blisters*	□ *Heart Disease/Heart Attack/Chest Pain*	□ *High Cholesterol*
□ *High Blood Pressure*	□ *Low Blood Pressure*	□ *Stroke*	□ *Seizures, Neurological or Psychiatric Problems*
□ *Bleeding Disorders/Blood Clots*	□ *Congenital Heart Lesions*	□ *Diabetes*	□ *Cancer*
□ *Stomach Problems/ Ulcers/Gastric Reflux*	□ *Kidney Disease*	□ *Liver Disease (Hepatitis or other liver disease)*	□ *HIV/AIDS (Chronic Viral Infection)*
□ *Lightheadedness or Fainting*	□ *Arthritis/Inflammatory Rheumatism (Painful Swollen Joints)*	□ *Venereal Disease*	□ *Persistent Cough or Cough Up Blood at Any Time*
□ *Tuberculosis*	□ *Anemia*	□ *Bruise easily*	

Do you have any disease, condition or problem NOT listed that you think the doctor and office should be aware of or know about? □ *Yes* □ *No*
If so, please explain: _____
_____

Personal Surgery History

Have you ever had any prior cosmetic procedures (Botox, fillers, etc.), breast augmentation/reduction, liposuction, tummy tuck, or other cosmetic surgery? □ *Yes* □ *No*
If so, please list _____
_____

Have you had any surgeries? This includes all minor procedures like Cataracts Removal, Wisdom Teeth, C-Sections, Gallbladders, ect? □ *Yes* □ *No*
If so, please list _____
_____

Do you have a personal or family history of reacting adversely in any way to the local anesthesia, general anesthesia, and/or malignant hyperthermia?
If yes, please describe the reaction _____

I, MYSELF, HAVE FILLED OUT THIS HEALTH QUESTIONNAIRE COMPLETELY AND I HAVE NOTIFIED THE OFFICE OF ALL MY MEDICAL PROBLEMS.

Patient's Signature _____ ***Date:*** _____/_____/_____