



Past Medical History and Health Assessment Form

Plastic Surgery
Steven Sigalove, MD

Full Name:

Phone (home):

Phone (work):

Phone (mobile):

Email (priority):

Preferred Contact (please circle one): Home, Work, Mobile, Email

SSN (last 4 digits):

Primary Care Physician: PCP Phone:

Who referred you or how did you become aware of Dr. Steven Sigalove's practice?

What specific aesthetic concerns are you interested in discussing at Consultation?

Thank you for choosing to visit with Dr. Steven Sigalove, Lori Anderson and the staff at the Institute of Aesthetic Surgery today. As part of our efforts to provide excellent care for you, we need your help in understanding your complete medical history. The questions on this form will assist us in giving you the best care possible. If you have any difficulties reading, writing, seeing, communicating or understanding that may require assistance, please ask for help and check here . If you are unsure how to answer a question, please ask the Patient Coordinator, Nurse or Doctor during your visit.

PAST MEDICAL HISTORY

Please list all current and previous medical illnesses and problems:

If none, please check here

1		5	
2		6	
3		7	
4		8	

If you choose not to disclose any medical history it could affect your surgical outcome.

Initials: _____

MEDICATIONS

Please list all current medications (prescription, over the counter and herbal):

If none, please check here

	NAME	DOSAGE	TIMES PER DAY	REASON FOR TAKING MEDICATION
1				
2				
3				
4				
5				
6				
7				
8				

If you choose to NOT disclose any prescription, over-the-counter or herbal medications it could affect your surgical outcome.

Initials: _____

PAST SURGICAL HISTORY

Please list all past surgeries:

If none, please check here

	OPERATION	YEAR	SURGEON
1			
2			
3			
4			
5			

If you choose not to disclose any surgical history it could affect your surgical outcome.

Initials: _____

Have you or any family member ever had problems or complications with any local or general anesthesia? Please explain:

Have you or any family members ever had problems or complications with excessive bleeding or a known blood clotting disorder? Please explain:

Are you pregnant, planning for impending pregnancy or is there any possibility that you may currently be pregnant?

ALLERGIES

Please list any medication allergies: _____ If none, please check here
Please list any food or environmental allergies: _____ If none, please check here
Please check if you are allergic to any of the following: Latex Tape Shellfish Iodine contrast/dye

SOCIAL HISTORY

Marital status Single Married Divorced Widowed
Occupation: _____ Employer: _____
Do you currently smoke? Yes No If yes, how many? _____ packs/day. How long? _____ years.
Have you ever smoked? Yes No How many? _____ packs/day. How long? _____ years. When did you quit? _____.
How many alcoholic drinks do you drink per week? _____ drinks/week.
Do you currently use or have you ever used cocaine, heroin, intravenous or other illegal drugs? Yes No

FAMILY HISTORY

Please list any medical diseases in your immediate relatives, including cancer:

Mother/Father: _____
Brothers/Sisters: _____
Children: _____

OVERVIEW OF YOUR CURRENT HEALTH

Please check yes or no if you experienced any of the symptoms or problems listed below:

Y	N		Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Fevers or chills	<input type="checkbox"/>	<input type="checkbox"/>	Bone, muscle or joint problems
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Depression, anxiety or mental illness
<input type="checkbox"/>	<input type="checkbox"/>	Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Skin conditions, growths or cancers
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Allergy or immune problems
<input type="checkbox"/>	<input type="checkbox"/>	Visual problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney, bladder or urination problems
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>	Sexual, gynecologic, or testicular problems
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Seizure, nerve or brain disorders
<input type="checkbox"/>	<input type="checkbox"/>	Heart problems (heart attack, pacemaker...)	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid, endocrine or hormone disorders
<input type="checkbox"/>	<input type="checkbox"/>	Stroke or headache problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis or infectious disease
<input type="checkbox"/>	<input type="checkbox"/>	Blood pressure or circulation problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Blood or lymph node diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B or C
<input type="checkbox"/>	<input type="checkbox"/>	Excessive or abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Excessive scarring
<input type="checkbox"/>	<input type="checkbox"/>	Stomach or digestive problems (ulcer, heartburn...)	<input type="checkbox"/>	<input type="checkbox"/>	Recent dental work
<input type="checkbox"/>	<input type="checkbox"/>	Sleep or snoring problems	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any other conditions or problems

Please explain if you answered yes to any of the above: _____

Height _____' _____"

Weight _____ lbs

I understand that all specific information for my informed consent for proposed procedures or treatments will be provided under separate cover after review of this information by Sigalove, MD. and his staff. I understand the above questions and have answered the questions as accurately and truthfully as possible. I understand that incomplete information may compromise my medical care and I agree to provide updated information to the physician if and when my medical information changes or is requested of me by or his staff.

Patient/Guardian Signature _____ Date _____