LAWRENCE MARTIN MD, FACS
COSMETIC AND RECONSTRUCTIVE FACIAL PLASTIC SURGERY
ENT - HEAD AND NECK SURGERY
Diplomate of the American Board of Otolaryngology-Head & Neck Surgery
Diplomate of the American Board of Facial Plastic and Reconstructive Surgery

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Confidential Health History for patient: _____ **Birthdate:**_____

Chief complaint:

_____

LIST ALL MEDICATIONS (including over-the-counter, vitamins, aspirins etc.)

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Medical Allergies: ☐ YES ☐ NO **If yes, please list:** _____

YOUR PAST MEDICAL/SURGERY HISTORY

Has this patient ever had any surgery and/or hospitalized? ☐ NO ☐ YES **if yes, please fill in below.**

Use back of page if you need additional space

Year	Facility	Reason/Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any other medical illnesses and/or problems that we should know about? ☐ NO ☐ YES **if yes, please fill in below**

Year	Illness/Problem	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health habits: Tobacco: _____ **Alcohol:** _____ **Drugs:** _____

Height: _____ **Weight:** _____ **Sleep, hours per night:**_____

SYSTEM REVIEW: Check NO if none, otherwise check those that apply.

General:	❑ NO	❑ Significant weight change ❑ Fevers
Hem/ONC:	❑ NO	❑ Bleeding or bruising problem ❑ Leukemia/ lymphoma
	❑ NO	❑ Any known cancer not otherwise noted? If so, what kind?_____
ALL/IMM:	❑ NO	❑ Hay fever ❑ Environment Allergy ❑ Food Allergy ❑ Latex Allergy
INF DZ:	❑ NO	❑ HIV and/or AIDS ❑ Hepatitis ❑ Weakened Immune System
ENDO:	❑ NO	❑ Thyroid problems ❑ Thyroid Nodule ❑ Diabetes
CV:	❑ NO	❑ High blood pressure ❑ Irregular heart beat ❑ Pacemaker
	❑ NO	❑ Heart attack ❑ Heart disease ❑ Heart surgery
	❑ NO	❑ Ever been told you need antibiotics before any dental procedure?
RESP:	❑ NO	❑ Emphysema ❑ Sleep Apnea ❑ COPD ❑ Asthma ❑ Tuberculosis
PHYSCH:	❑ NO	❑ Chemical Dependency ❑ Alcoholism ❑ Psychiatric illness
GU:	❑ NO	❑ Kidney Disease ❑ Dialysis ❑ Renal insufficiency
NEURO:	❑ NO	❑ Headaches ❑ Stroke ❑ TIA ❑ Migraines
OPHTH:	❑ NO	❑ Loss of vision ❑ Double vision ❑ Glaucoma
ENT:	❑ NO	❑ Speech/language delays/problems ❑ Sinus problems ❑ Ear Pain ❑ Vertigo
	❑ NO	❑ Prior Head/Neck/Face trauma or surgery_____
	❑ NO	❑ Prior Cosmetic Surgery _____

FAMILY HISTORY: Do any of the patient's blood relatives have/had any of the following?

Please circle all that apply: ❑ Bleeding or bruising problems ❑ Problems with anesthesia ❑ Hearing loss ❑ Asthma ❑ Thyroid disease ❑ Cancer ❑ Autoimmune disease ❑ Other: _____

Patient/Guardian signature: _____ **Date:** _____