

Intimate Cosmetic Surgery

Patient Health Information

This is a **Confidential Record**: Information contained here will not be released unless you have authorized us to do so. Please print legibly, complete both sides, and answer all questions to the best of your knowledge.

Name: _____ Reason for Visit: _____

Date of Birth: _____ Age: _____ Gender: _____ Height: _____ Weight: _____

Current Physicians: _____

Do you have or have you had any of the following (circle for each, give date occurred if yes):

AIDS/HIV	No	Yes	Eating disorders	No	Yes	Lupus	No	Yes
Anemia	No	Yes	Epilepsy/Seizures	No	Yes	Pneumonia/Bronchitis	No	Yes
Arthritis	No	Yes	Glaucoma	No	Yes	Reflux/ulcers	No	Yes
Asthma	No	Yes	Goiter/Thyroid disease	No	Yes	Rheumatic fever	No	Yes
Blood clots in lungs/legs (DVT)	No	Yes	Hay Fever/Allergies	No	Yes	Sinus problems/infections	No	Yes
Blood transfusions	No	Yes	Headaches/Migraines	No	Yes	Sexually transmitted diseases	No	Yes
Bowel problems	No	Yes	Heart problems	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Hepatitis	No	Yes	Tuberculosis	No	Yes
Depression	No	Yes	High blood pressure	No	Yes	Other		
Diabetes	No	Yes	Kidney problems	No	Yes			

List all surgeries (hospital and date of occurrence):

List any serious illnesses and/or accidents:

List the name of all medications you are presently taking or have taken in the last month. Please include the name of the drug, dosage and frequency.

List ALL drugs and/or latex allergies.

Do you currently have any of the symptoms listed below (circle if yes):

Weight loss/weight gain	Chronic cough	Urine loss when coughing/sneezing	Hair loss
Glasses/contacts	Frequent diarrhea or constipation	Muscle or joint pain	Heat/cold intolerance
Hearing problems	Nausea/vomiting/indigestion	Rash/sores	Hot flashes
Dental problems	Involuntary loss of gas or stool	Problems with scarring	Frequent large bruises
Chest pain	Need to help bowel movement out	Breast pain or discharge	Cuts do not stop bleeding
Difficulty breathing	Strong urgency to urinate	Memory problems	Enlarged lymph nodes/glands
Rapid or irregular heartbeat	Frequent urination	Depression	Problems with anesthesia
Shortness of breath	Involuntary/unintended urine loss	Anxiety	Prostate problems (men)
Other:		Decreased sex drive	

Do any of your blood relatives have any of the following? (circle yes or no for each; if yes give age at onset and list if mother, father, sibling, etc.):

Alzheimer's Disease	No	Yes	High blood pressure	No	Yes
Birth Defects	No	Yes	Mental Illness/Depression	No	Yes
Blood clots in lungs or legs (DVT)	No	Yes	Osteoporosis (weak bones)	No	Yes
Breast cancer	No	Yes	Ovarian cancer	No	Yes
Colon cancer	No	Yes	Prostate cancer	No	Yes
Diabetes	No	Yes	Stroke	No	Yes
Drinking or drug problems	No	Yes	Uterine cancer	No	Yes
Heart Disease	No	Yes	Other		

Do you smoke? No Yes **If yes, how much?** _____ Pack(s)/day **How long?** _____ Years
Do you drink alcohol? No Yes **If yes, how much?** _____ **How often?** _____
Do you use recreational drugs? No Yes **If yes, describe:** _____
Sexual orientation: Heterosexual ___ Homosexual ___ Bisexual ___ Transgender ___
Marital Status: Married ___ Living w/partner ___ Single ___ Widowed ___ Divorced ___
Current or most recent job: _____

WOMEN please list the following:

	Number		Number		Number
Pregnancies		Abortions		Miscarriages	
Premature Births (<37 wks)		Live births		Living children	

No.	Birth date	Birth weight	Baby's sex	Weeks pregnant	Type of Delivery (Vaginal, Cesarean)	Complications
1.						
2.						
3						
4						

Please fill in the answers to the following questions:

First day of last period?	Present method of birth control
Regular menses?	Have you ever had an abnormal pap test?
Recent changes in periods?	Do you have abnormal vaginal bleeding or fibroids?
Are you currently sexually active?	Do you have painful periods, painful intercourse or PMS?
Have you ever had sex?	Do you experience vaginal "noises" with sex?
Number of sexual partners (lifetime): circle ≤10 >10	Have you had infertility?
Sexual partners are (circle) Men Women Both	Have you been exposed to DES?

MEN please circle any of the following symptoms that apply to you:

Decrease in sex drive	Decreased "enjoyment of life"
Erections less strong	Sad and/or grumpy
Lack of energy	Deterioration in sports ability
Decrease in strength or endurance	Falling asleep after dinner
Lost height	Decreased work performance

The above information is accurate and complete to the best of my knowledge.

Signature _____ **Date** _____