Coastal Islands Cosmetic & Reconstructive Surgery
772-204-8870
HEALTH HISTORY FORM - Page 1

Name: _____ DOB: _____ Height: _____ Weight: _____

Occupation: _____Employer Name: _____

Reason for today's visit: _____

Primary Physician or Referring Physician: _____ Phone#:_____

Pharmacy Name, Address &Phone#: _____

Have you had a Flu Shot: Yes ☐ No ☐ When: _____

Pneumonia Vaccination: Yes ☐ No ☐ When: _____

Are you pregnant: ☐ Yes ☐ No If Yes, how far along: _____
Are you Breast feeding: ☐ Yes ☐ No

List Any Surgeries/Hospitalizations:

_____

_____

Social History:
Do you Smoke or use Tobacco: ☐ No ☐ Yes If yes, how long & how many packs per day_____
Do you use Alcohol: ☐ No ☐ Yes If yes how frequently: _____
Do you use recreational drugs: ☐ No ☐ Yes If yes how frequency: _____
Do you have a Pacemaker or Defibrillator: ☐ No ☐ Yes
Do you have any Artificial Joint or heart valve: ☐ No ☐ Yes
Do you take antibiotics prior to any surgical procedures: ☐ No ☐ Yes
Do you form Keloids: ☐ No ☐ Yes

Review of Systems (Current or past problems with) Please check ALL that apply
☐ Cancer, Please list what type & Location: _____

☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Blood clots
☐ Chest pain
☐ Depression
☐ Diabetes
☐ Dizziness
☐ Heart Attack
☐ Heart Disease
☐ High Blood Pressure
☐ Hives
☐ Infectious disease (TB, HIV)
☐ Insomnia
☐ Kidney Disease
☐ Liver disease
☐ Lung Disease
☐ Melanoma
☐ Palpitations
☐ Received Blood Transfusions
☐ Shortness of breath on exertion
☐ Skin Cancer
☐ Stroke
☐ Thyroid
☐ Thyroid Disease
☐ Tremors

Family Medical History: Check all that apply which have occurred in your family.

Disease	Mother	Father
Arthritis	☐	☐
Skin Cancer	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Melanoma	☐	☐
Hives	☐	☐

Patient Signature: _____ **Date:** _____

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HEALTH HISTORY FORM - Page 2

Name: _____ **DOB:** _____

Allergies to Medications: ☐ Yes ☐ No If yes, please List: _____

Current Medications: ☐ Yes ☐ No If Yes, Please list ALL Medications and Dosages:

Current Medications	**Dosage & Frequency**

Patient Signature: _____ **Date:** _____