Wellesley Cosmetic Surgery

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Patient Questionnaire

Please check yes or no for each question

☐ Yes ☐ No 1. Do you have any allergies to medications? Which medications and what is the reaction?

_____

_____

☐ Yes ☐ No 2. Do you smoke? How much? _____

☐ Yes ☐ No 3. Do you have a latex allergy? Are you allergic to eggs? Are you allergic to soybean oil?

☐ Yes ☐ No 4. Do you drink alcohol? If yes how, much? _____

☐ Yes ☐ No 5. Do you or anyone in your family have problems with anesthesia such as fevers, not waking up easily, or history or malignant hyperthermia?

☐ Yes ☐ No 6. Have you taken steroids or prednisone within the last year?

☐ Yes ☐ No 7. Do you have high blood pressure or are you being treated for high blood pressure?

☐ Yes ☐ No 8. Do you have a history of angina, chest pain or chest pressure?

If yes, how often does it occur? _____

Does it radiate? ☐ Yes, from _____ to _____ ☐ No

Do you take nitroglycerin to relieve the pain? ☐ Yes ☐ No

If yes how many does it take? _____

If no, what do you do to obtain relief? _____

☐ Yes ☐ No 9. Have you had a heart attack? If yes, when _____

☐ Yes ☐ No 10. Do you have palpitations?

☐ Yes ☐ No 11. Do you have asthma? If yes, have you ever had to go to the ER? ☐ Yes ☐ No

If yes, when? _____

☐ Yes ☐ No 12. Have you had hepatitis? If yes, what type? _____

☐ Yes ☐ No 13. Do you have neurological problems such as a history of seizures, history of stroke, history of passing out, any numbness, tingling, or weakness anywhere in the body?

☐ Yes ☐ No 14. Do you have any heartburn or reflux problems?

☐ Yes ☐ No 15 Do you bleed or bruise easily?

☐ Yes ☐ No 16 Have you had a blood transfusion?

☐ Yes ☐ No 17. Do you have diabetes? If yes, for how long? _____

☐ Yes ☐ No 18. Do you take insulin?

☐ Yes ☐ No 19. Are you or could you be pregnant?

☐ Yes ☐ No 20. Do you have dentures, caps, bridges, false teeth or loose teeth?

☐ Yes ☐ No 21. Do you have any other problems of which we should be aware? If yes, please describe below:

_____