PATIENT HISTORY/ALL INFORMATION IS STRICTLY CONFIDENTIAL

Name: _____ Birth date: _____ Age:_____

Referred by: ◯ Physician: _____ ◯ Magazine ◯ Friend ◯ Other _____

Height: _____ Weight: _____ Religion: _____

PAST MEDICAL HISTORY

FAMILY HISTORY

Relation	Age	State of Health	Age of Death	Cause of Death or Health Issues	Check if your blood relations have/had any of the following:
Father					Arthritis, Gout
Mother					Asthma, Hay fever
Brothers					Breast Cancer
					Diabetes
					Heart Disease
Sister					Hypertension
					Kidney disease
					Tuberculosis
					Other

MEDICATIONS: List medications you are currently taking	**ALLERGIES**: To any medications or substance

Do you currently take any opioids (pain medication)? ◯ No ◯ Yes ☐ Oxycodone ☐ Fentanyl ☐ Hydrocodone ☐ Dilaudid ☐ Codeine ☐ Demerol ☐ Methadone ☐ Other: _____

PAST MEDICAL CONDITIONS

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Asthma
- ☐ Anorexia
- ☐ Arthritis
- ☐ Gallbladder disease
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chicken Pox
- ☐ HIV
- ☐ Colitis/Ulcers
- ☐ Constipation/Rectal bleeding
- ☐ DES
- ☐ Diabetes
- ☐ Mumps
- ☐ Heart disease
- ☐ Headaches/migraines
- ☐ Hepatitis/Liver disease
- ☐ Hirsutism (excessive hair growth)
- ☐ Hypertension
- ☐ Hyperlipid
- ☐ Kidney disease/Stones
- ☐ Measles
- ☐ Pacemaker
- ☐ Painful urination/incontinence
- ☐ Phlebitis/blood clots
- ☐ Pneumonia
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Rubella
- ☐ Thyroid Disorder
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Syphilis
- ☐ Seizure disorder/epilepsy
- ☐ COVID-19 ***
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Do you have an Advance healthcare directive? ◯ **Yes** ◯ **No**

An advance healthcare directive, also known as living will, personal directive, advance directive, medical directive or advance decision, is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.

PLEASE COMPLETE OTHER SIDE

SURGICAL HISTORY

Date	*Surgery*	*Physician*	*Hospital*	*Complications*

HEALTH HABITS: Please check which substance you use and describe how much/often you use them.			**OCCUPATIONAL CONCERNS:** Please check if your employment exposes you to any of the following.	
☐	Alcohol		☐	Stress
☐	Caffeine		☐	Hazardous Substances
☐	Drugs		☐	Heavy Lifting
☐	Tobacco		☐	Other
☐	Vaping			
☐	OTHER			

Completed by: ◯ Patient ◯ Office Nurse ◯ Physician ◯ Other: _____

Signature of Patient: _____ Date: _____

Date reviewed by physician with patient: _____

Physician's signature: _____

Annual Review of History:

Date reviewed: _____ Date reviewed: _____

Date reviewed: _____ Date reviewed: _____

Date reviewed: _____ Date reviewed: _____

Date reviewed: _____ Date reviewed: _____

CHRISTIANA
cosmetic surgery consultants
Jonathan N. Saunders, M.D., F.A.C.S.
Katheryn M. Warren, M.D., F.A.C.S.
Julia MacRae, M.D.
E-62 Omega Dr Newark, DE 19713
Phone: (302) 368-9611
Fax: (302) 368-3424

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