



JOHN L. WILLIAMS, MD
NORTH SCOTTSDALE PLASTIC SURGERY

AESTHETIC SURGERY

MEDICAL HISTORY

NAME _____

Date of last physical exam _____ Chest X-ray _____ EKG _____

Primary Care Physician _____ Phone _____

Height _____ Weight _____ Do you wear dentures? _____ Contact lenses? _____

Are you currently being treated for any illness? _____

Do you now have or have you ever had... (please circle yes or no)

Arthritis.....	Yes	No	High Blood Pressure.....	Yes	No
Asthma.....	Yes	No	Kidney disease.....	Yes	No
Bleeding Tendencies.....	Yes	No	Leukemia.....	Yes	No
Cancer.....	Yes	No	Migraines.....	Yes	No
Colitis.....	Yes	No	Mental Illness.....	Yes	No
Congenital Heart Disease.....	Yes	No	Pneumonia.....	Yes	No
Diabetes.....	Yes	No	Rheumatic Heart Disease.....	Yes	No
Epilepsy.....	Yes	No	Stomach Ulcers.....	Yes	No
Goiter.....	Yes	No	Stroke.....	Yes	No
Hay Fever.....	Yes	No	Tonsillitis.....	Yes	No
Heart Attack.....	Yes	No	Tuberculosis.....	Yes	No
Hepatitis.....	Yes	No			

Have you had any serious illnesses not listed? _____

Do you smoke? _____ How much and for how long have you smoked? _____

Do you regularly drink alcohol? _____ If yes, how much and how often? _____

List ANY medications, vitamins, herbs taken in the last month _____

List any **allergies to medications, tape, etc.** _____

List **ALL** previous surgeries(including cosmetic procedures) and the date of each _____

Have you ever had any complications following anesthesia? No Yes Explain _____

Do you take aspirin or blood thinners on a regular basis? No Yes Explain _____

Do you bruise easily? No Yes

Do you bleed excessively following a tooth extraction? No Yes

Have you ever had a blood transfusion? No Yes When _____

List any illnesses that run in your family _____

Women Only: Is there a chance that you might be pregnant? _____