AUSTIN PLASTIC SURGERY INSTITUTE
& SKIN CARE CLINIC

Health History Questionnaire | Dr. Justin Booth

Name: _____ DOB: _____ AGE: _____

VITALS HT: _____ WT: _____ BP: _____ HR: _____ O2: _____

	YES	NO	If yes, explain
HEART			
Heart Attack			
Chest Pain			
High Blood Pressure			
Family history of heart disease			Which family member?
LUNGS			
Respiratory Issues			
Sleep apnea			
Asthma			
DIGESTIVE TRACT			
Reflux/ Heartburn			
Hepatitis			
MUSCLE/BONE			
Muscle Weakness			
Arthritis			
NEUROLOGICAL			
Seizures			
Depression			
Headache			
BLEEDING			
Bleeding/Clotting Problems			
METABOLIC			
Diabetes			
Thyroid			
BREAST			
Breast Masses			
Family history: breast cancer/ masses?			Which family member?

Medication List: Please list all medication including over the counter, herbals, and vitamins.

NAME	DOSAGE	HOW LONG HAVE YOU BEEN TAKING IT?

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HEALTH HISTORY CONTINUED

ANY PREVIOUS SURGERIES:

PROCEDURE:	WHEN/WHERE	WHY?

Preferred Pharmacy (include which location): _____

Primary Doctor (include address & phone number: _____

Any drug allergies (if yes, please list allergy and reaction): _____

_____

Do you smoke tobacco (if yes, for how long?) _____

Do you drink alcohol? _____

Any pregnancies? _____ How many? _____ Did you breastfeed? _____

Any other health concerns your doctor should know about? _____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold the staff at Austin Plastic Surgery Institute responsible for any errors or omissions that I may have made in the completion of this form. I acknowledge that I have received the Notice of Privacy Practices.

Signature/Date:

_____