Houston Cosmetic Surgery Center
Dr. David D. Davila
12814 Willow Centre Dr.
Houston, Texas 77066
(281) 453-5100

MEDICAL HISTORY

Please circle correct responses or fill in the blanks where applicable.

NAME:_____________________________ DATE: __________ AGE:____ Ht:____ft___in____wt___lb.

YES NO 1. Are you considered a healthy person? Please circle: Male or Female
YES NO 2. Are you taking any drugs or medications? How often? Hormone patch?
List them:____
YES NO 3. Are you allergic to any medications?____
YES NO 4. Have you had any children? If so, how many?_____________________________________
YES NO 5. Did you breast feed? How old is the youngest child? ______________________________
YES NO 6. Are you or have you been on a weight loss program?
7. Name of primary care physican ______________________ Office Phone # ____________

8. Do any ***family members*** have the following:

Heart Trouble	**Excessive Bleeding Tendencies**	**Tuberculosis**	**High Blood Pressure**
Diabetes	**Breast Cancer**	**Asthma**	**Psychiatric Problems**
Thyroid Problems	**Excessive Scarring**	**Excessive Bruisability**	**Other**

9. **Do you or have you ever had the following?**

YES NO Fibrocystic changes of the breast?	YES NO Heart trouble? (Mit. valve prolapse,murmur)
YES NO Blood pressure related problems?	YES NO Asthma or other respiratory problem?
YES NO Liver, gallbladder trouble, yellow jaundice or hepatitis?	YES NO Kidney disease?
YES NO Diabetes?	YES NO Bleeding tendency?
YES NO Epilepsy, convulsions or seizures?	YES NO Any other illnesses?
YES NO Back **OR** neck surgery?	YES NO Abnormal chest x-rays?
YES NO Abnormal electrocardiogram (EKG)?	YES NO Any recent medical/dental infections?
YES NO Have you had a mammogram? When?___________	YES NO Thyroid Problems?
YES NO Hiatal Hernia?	YES NO Blood clots?

10. Do You...
YES NO Wear contact lenses?
YES NO Smoke? How much?__________________

11. YES NO Are you pregnant? Date of last menstrual period.________________

12. PLEASE LIST ALL PREVIOUS SURGERIES INVOLVING GENERAL ANESTHESIA........

SURGERY:	DATE:
____________________________	_____________________
____________________________	_____________________
____________________________	_____________________

Signature:_______________________________________ Date:______________________