



CENTER FOR PLASTIC & AESTHETIC SURGERY MEDICAL HISTORY

Patient Name: _____ Age: _____ Height _____ ' _____ " Weight _____

1. Disease History: Please mark appropriate box:

Table with 12 columns (Lung, Vascular, Systematic) and 3 rows (Past, Present, No) for various medical conditions like Bronchitis, Pneumonia, Sinusitis, etc.

If you marked any of the past/present boxes above, please explain each one:

2. Drug History: In the past six months, have you taken any of the following drugs:

Table with 12 columns (Steroids, Birth Control Pills, Antibiotics, Thyroid Medication, Blood Pressure, Insulin, Narcotics, Blood Thinners, Aspirin, Arthritis/Joint Meds, Heart Medication, Water Pills, Tranquilizers, Other) and 3 rows (Past, Present, No).

If you marked any of the past/present boxes above, please explain each one:

List all of the medications or substances that you are currently taking:

3. Allergies and Reactions: If none, Please state "None" _____

- Narcotic:Drug _____ Reaction: _____
Local Anesthetic:Drug _____ Reaction: _____
Antibiotic:Drug _____ Reaction: _____
Environmental:List _____ Reaction: _____
Topical:List _____ Reaction: _____
Other:List _____ Reaction: _____

4. Please list all hospitalizations and operations that you have had and give approximate dates:

5. Have you or your family members had problems with anesthesia? If yes, please explain:

- 6. Do You Smoke? _____ If yes, how much? _____
7. Do you drink alcohol? _____ If yes, how much? _____
8. Date of last menstrual period? _____ Are you menopausal? _____
9. Could you be pregnant? _____
10. Do you have any physical limitations? _____
11. Are the any health problems not mentioned above that we should know about? _____

The answers that I have given represent a true and complete history to the best of my knowledge.

Signature _____ Date: _____