Center for Plastic Surgery — Medical History Form

NAME: | **Birth Date:** / /

ALLERGIES: List specific & add reaction (Rash, Breathing Problem, Other)
[ ]Penicillin; [ ] Cephalosporin; [ ] Sulfa; [ ]Mycins
[ ]Other Antibiotics ____
[ ]Darvon; [ ]Codeine; [ ]Morphine; [ ] Demerol;
[ ]Aspirin ____
[ ]Local Anesthetic ____
[ ]Tetanus Antitoxin or Serums ____
[ ]Other Meds. ____
[ ]Tape ____
[ ] Latex ____
[ ]Soaps; [ ]Iodine; [ ]Shellfish ____
[ ]Nail Polish or other cosmetic ____
[ ]Any foods ____
[ ]Other ____
Date of last Tetanus Shot: / /

MEDICATIONS x If taking or have taken regularly in the last year; list name, dose, & date
[ ] Acutane ____ [ ] Hormones ____
[ ] Antacids ____ [ ] Sleeping Pills ____
[ ] Antibiotics ____ [ ] Tamoxifen ____
[ ] Anti-inflammatory ____ [ ] Thyroid Meds. ____
[ ] Aspirin, Alieve, Ibuprofen, Etc. ____ [ ] Tranquilizers ____
[ ] Birth Control Pills ____ [ ] Water Pills ____
[ ] Blood Pressure Meds ____ [ ] Other Prescriptions ____
[ ] Blood Thinning Meds ____
[ ] Cortisone-Steroid ____ [ ] Multivitamins [ ] Ginko Biloba
[ ] Cough Medicine ____ [ ] Vitamin E [ ] Ginseng
[ ] Danocrin ____ [ ] Echinacea [ ] Kava
[ ] Digitalis ____ [ ] Ephedra [ ] St John's Wort
[ ] Dilantin ____ [ ] Garlic [ ] Valerian
[ ] Insulin, Diabetic Meds ____ [ ] Other Vitamins ____
[ ] Other Dietary Supplements or Herbals ____
[ ] Anti-Cholesterol ____
[ ] I have been treated for a drug or alcohol dependen[ ] I have or am presently using a controlled drug?

TRANSFUSIONS: Have you ever had a Blood or Plasma transfusion?
[ ]No,[ ]Yes; Reaction [ ]No,[ ]Yes, What? ____
Will you take Blood if needed? [ ]Yes, [ ]No

Height:
Weight:Now ______ year ago ______
Maximum When?

Have you (ME) or a blood relative (BR) had or currently have any of the following conditions?

ME BR	ME BR	ME BR	ME BR	ME BR
[ ] [ ] Anemia	[ ] [ ] High Blood Pressure	[ ] [ ] Hepatitis	[ ] [ ] Collagen Disease	[ ] [ ] Breast Disease/Lumps
[ ] [ ] Circulation Pblms.	[ ] [ ] Stroke	[ ] [ ] Kidney Disease	[ ] [ ] Uterine Cancer	[ ] [ ] Tumor, Other Cancer
[ ] [ ] Heart Trouble	[ ] [ ] Tuberculosis	[ ] [ ] Gout	[ ] [ ] Breast Cancer	[ ] [ ] HIV (Tested Y [ ],N [ ])
[ ] [ ] Heart Attack	[ ] [ ] Diabetes	OTHER ____		

DO YOU:	X	Daily Use
Smoke?	[ ]	____ Pkgs
Use other tobacco products?	[ ]	____
Secondary Smoke Exposure	[ ]Yes, [ ]No.	
Drink coffee, tea, colas?	[ ]	____ oz.
Eat chocolate or other foods/meds with caffeine?	[ ]	____
Drink Alcohol?	[ ]	____ oz.
Drink Beer?	[ ]	____ oz.
Women, Are you pregnant?	[ ]Yes, [ ]No	

Please explain any positive history, or *disease related* reason any *close relative* died.

Serious illness NOT requiring hospitalization & Yr.?

Regular Exercise, Type, Amount, & Frequency

Skin Care

Have you had or do you have problems with any of the following, except that for which you are here? (Please explain.)

[ ] Back Problem	[ ] Chest Pain	[ ] Appetite	[ ] Prolonged Bleeding	[ ] Leg Pains/Cramps	[ ] Feeling blue, Moods
[ ] Joint Pains, Aches	[ ] Heart Murmur	[ ] Difficulty swallowing	[ ] Bruise Easily	[ ] Leg Swelling	[ ] Stress
[ ] Stiff Joints	[ ] Racing Heart	[ ] Indigestion, Digestion	[ ] Herpes (feverblisters)	[ ] Hearing	[ ] Nervous Breakdown
[ ] Asthma/Bronchitis	[ ] Rheumatic Fever	[ ] Stomach Pblm	[ ] Keloid/Poor Scar	[ ] Seeing	[ ] Nose, Smelling
[ ] Breathing	[ ] Bladder Trouble	[ ] GI Ulcer	[ ] Skin Cancer	[ ] Glaucoma	[ ] Sleeping
[ ] Cough	[ ] Prostate Problem	[ ] Bowel Pblm, Colitis	[ ] Melanoma	[ ] Balance, Dizziness	[ ] Thyroid
[ ] Hoarseness	[ ] Urinary Pblm.	[ ] Change in Bowel Habits	[ ] Non-healing sore	[ ] Seizures	[ ] Salivary Gland
[ ] Shortness of Breath	[ ] OTHER				

Explanations for those checked above.

Disease or illness you have had requiring hospitalization & Yr.?

Operations you have had including Cosmetic surgery, injuries, or broken bones. Include type of Anesthesia, any problems & year?