PATIENT MEDICAL INFORMATION

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PLASTIC MEDICAL, LLC

HEIGHT: _____ WEIGHT: _____

DRUG ALLERGIES: ◯NONE ◯PENICILLIN ◯IODINE CONTRAST ◯SULFA ◯LATEX

OTHER ALLERGIES: _____

SMOKING HISTORY: ◯YES ◯NO WHEN STARTED: _____ WHEN YOU QUIT: _____

HOW MUCH DO YOU SMOKE: _____ DO YOU USE VAPOR CIGARETTES OR PIPE: ◯Y ◯N

NICOTINE GUM OR PATCH: ◯Y ◯N CIGARS: ◯Y ◯N

MEDICATIONS: PLEASE LIST ALL PRESCRIPTION AND NON PRESCRITION MEDICATIONS YOU TAKE INCLUDING SUPPLEMENTS, HERBALS, HORMONES AND DIET PILLS

_____
_____
_____
_____

YOUR PERSONAL MEDICAL HISTORY

◯ASTHMA	◯HEART DISEASE	◯PERIPHERAL VASCULAR DISEASE
◯LUNG PROBLEMS	◯HEART ATTACK	◯PREGNANT
◯AUTOIMMUNE DISORDERS	◯HEPATITIS	◯SEIZURES
◯CONNECTIVE TISSUE DISEASES	◯HIV/AIDS	◯SKIN CANCER
◯ARTHRITIS	◯HIGH BLOOD PRESSURE	◯STROKE
◯BLEEDING DISORDERS	◯KIDNEY PROBLEMS	◯THYROID DISEASE
◯DEMENTIA	◯LIVER DISEASE	◯CANCER: TYPE _____
◯DIABETES	◯HERPES OR FEVER BLISTERS	◯BLOOD CLOTS OR THROMBOSIS
◯DRY EYE CONDITION	◯INFECTIONS	◯ORGAN TRANSPLANT

DO YOU HAVE ANY DISEASE OR CONDITION NOT MENTIONED ABOVE THAT WE SHOULD BE AWARE OF?

_____

HAVE YOU OR ANY FAMILY MEMBER HAD A REACTION TO ANESTHESIA? ◯Y ◯N

LIST ALL OPERATIONS OR PROCEDURES YOU HAVE HAD:

_____
_____
_____
_____