

NAME _____ HEIGHT _____ WEIGHT _____

PLEASE BE EXTREMELY ACCURATE WHEN ANSWERING ALL MEDICAL QUESTIONS. YOUR ANSWERS COULD INFLUENCE YOUR POST-OP RECOVERY AND FINAL RESULT!

Drug Allergies _____

Are you Allergic to Latex? Y N Other Allergies (i.e. iodine, tape, skin sensitivity) _____

Present Medications (*Include herbs, vitamins, over-the-counter meds, hormones and contraceptives*) _____

Have you ever had surgery? Y N (*include Plastic/Cosmetic surgery*) Please list the surgeon, procedure and year _____

Have you had any reactions to anesthesia? Y N If yes, please describe _____

PLEASE INDICATE WHICH CONDITION(S) YOU HAVE BY CHECKING THE BOX(ES):

- | | | |
|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Scarring | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes Simplex 1 | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes Simplex 2 | <input type="checkbox"/> Y <input type="checkbox"/> N Restless Leg Syndrome |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Hyperpigmentation | <input type="checkbox"/> Y <input type="checkbox"/> N Scleroderma |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Keloid | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease | <input type="checkbox"/> Y <input type="checkbox"/> N STD (type) _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hemangiomas | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N Port Wine Stain | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis (type) _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Positive HIV test | Other: _____ |

Have you ever been under the care of a psychiatrist/psychologist? Y N, When _____

When was your last physical examination? _____ Who was the physician? _____

Do you wear contact lenses? Y N Do you wear dentures? Y N

Have you ever had a mammogram? Y N When? _____ Where? _____

Personal or Family History of Clotting Disorders? Y N

Do you smoke? Y N, Have you ever smoked? Y N, If yes, for how long? _____ when _____

When did you quit smoking? _____ Do you drink alcohol? Y N If yes, how much? _____

Do you take aspirin, Motrin, Nuprin, Ecotrin or Advil on a regular basis? _____ if so, how much? _____

SIGN _____ DATE _____