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):

☐Y ☐N Abnormal Scarring	☐Y ☐N Herpes Simplex 1	☐Y ☐N Respiratory Problems
☐Y ☐N Asthma	☐Y ☐N Herpes Simplex 2	☐Y ☐N Restless Leg Syndrome
☐Y ☐N Bleeding Disorder	☐Y ☐N High Blood Pressure	☐Y ☐N Rheumatic Fever
☐Y ☐N Diabetes	☐Y ☐N Hyperpigmentation	☐Y ☐N Scleroderma
☐Y ☐N Glaucoma	☐Y ☐N Keloid	☐Y ☐N Seizures
☐Y ☐N Heart Problems	☐Y ☐N Kidney Disease	☐Y ☐N STD (type)_____
☐Y ☐N Hemangiomas	☐Y ☐N Lupus	☐Y ☐N Shortness of Breath
☐Y ☐N Hemophilia	☐Y ☐N Port Wine Stain	☐Y ☐N Thyroid
☐Y ☐N Hepatitis (type)_____	☐Y ☐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_____