NAME_____HEIGHT_____WEIGHT_____

PLEASE BE EXTREMELY ACCURATE WHEN ANSWERING ALL MEDICAL QUESTIONS. YOUR ANSWERS COULD HAVE AN EFFECT ON 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 CONDITIONS(S) YOU HAVE BY CHECKING THE BOX(ES):

☐ Abnormal Scarring	☐ Hepatitis (type)_____	☐ Respiratory Problems
☐ Asthma	☐ High Blood Pressure	☐ Restless Leg Syndrome
☐ Bleeding Disorder	☐ Hyperpigmentation	☐ Rheumatic Fever
☐ Diabetes	☐ Keloid	☐ Scleroderma
☐ Glaucoma	☐ Kidney Disease	☐ Seizures
☐ Heart Problems	☐ Lupus	☐ Sexually Transmitted Diseases
☐ Hemangiomas	☐ Port Wine Stain	☐ Shortness of Breath
☐ Hemophilia	☐ Positive HIV test	☐ Thyroid

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_____