What is your main reason for your visit?

PATIENT MEDICAL HISTORY:

Question	No	Yes
Do you have any medical problems?	☐ No	☐ Yes
If Yes, Please explain:		
Do you suffer from any of the following medical conditions, now or in the past?		
High Blood Pressure	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Heart Disease	☐ No	☐ Yes
High Cholesterol	☐ No	☐ Yes
Stroke	☐ No	☐ Yes
Thyroid Disease:	☐ No	☐ Yes
If Yes, (circle one) Hypoactive Hyperactive		
Asthma: If Yes, Last Attack?	☐ No	☐ Yes
Lung Disease	☐ No	☐ Yes
Kidney Disease	☐ No	☐ Yes
Varicose Veins or DVT (Blood clots in leg veins)?	☐ No	☐ Yes
Cancer:	☐ No	☐ Yes
If Yes, Please specify type of cancer and treatment/year:		
Melanoma	☐ No	☐ Yes
Have you ever had a blood transfusion?	☐ No	☐ Yes
Other (Please specify)	☐ No	☐ Yes
Do you exercise?	☐ No	☐ Yes
Have you ever had an ulcer?	☐ No	☐ Yes
Have you ever had Hepatitis?	☐ No	☐ Yes
If Yes, What type? (circle one) A B C		
Have you been diagnosed with having HIV?	☐ No	☐ Yes
Have you ever been under the care of a psychiatrist or other mental health care professional?	☐ No	☐ Yes
If Yes, For what reason?		
Have you had plastic surgery in the past?	☐ No	☐ Yes
Which type?		
Name of plastic surgeon:		
Town/City/Country:		
Any complications?	☐ No	☐ Yes

PAST SURGICAL HISTORY:

Please list past surgeries and any complications of the surgery or anesthesia:

Procedure, Month/Year:
Doctor/Place:
Complication(s) if any:

Procedure, Month/Year:
Doctor/Place:
Complication(s) if any:

Are you allergic to any medication(s)? ☐ No ☐ Yes
Please explain which ones and what type of reaction you have:

FAMILY HISTORY:

Do any family members suffer from medical conditions:	☐ No	☐ Yes
Mother: (Specify Type of Illness: ___________________________)	☐ No	☐ Yes
Father: (Specify Type of Illness: ___________________________)	☐ No	☐ Yes
Brother(s): (Specify Type of Illness: ___________________________)	☐ No	☐ Yes
Sister(s): (Specify Type of Illness: ___________________________)	☐ No	☐ Yes
Children: (Specify Type of Illness: ___________________________)	☐ No	☐ Yes

HEALING HISTORY:

Do you experience delayed healing of wounds?	☐ No	☐ Yes
Do you experience poor scarring? (Keloids, red or widespread scars)	☐ No	☐ Yes
Do you bruise easily?	☐ No	☐ Yes

ATTESTATION:

I certify that the information given by me is correct. I understand that false information given can be dangerous for my health. It is my responsibility to notify the physician and staff of any changes in my medical history.

Signature: ____ Date: _____ / ______ / ________