Main Line Plastic Surgery Medical History

Patient Name: Today's Date:
Patient No.: Surgeon Name:

In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of the specialist physician not being aware of the general health and medical background of the patient. On occasion such information may critically affect what procedures we can safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information.

Age: ________Height: _______________Weight: ______________Occupation: ______________________________

Reason for seeing a plastic surgeon: ____

Please Circle any areas of interest: Botox Restylane/Juvaderm Skin Care/Peels/Laser Laser Hair Removal

Facelift Eyelid Surgery Breast Augmentation Tummy Tuck Breast Lift / Reduction

List any medications you are taking, including non-prescription drugs, vitamins, and herbals:

1.________________________Dosage______4.________________________Dosage______7.__________________________Dosage_____

2.________________________Dosage______5.________________________Dosage______8.__________________________Dosage_____

3.________________________Dosage______6.________________________Dosage______9.__________________________Dosage_____

List all drug allergies and reaction:____

____

Have you ever used (circle any that apply)? LSD Cocaine Marijuana None
Are you a (circle one): Smoker Ex-Smoker Non-Smoker

If you are/were a smoker, how much are/were you smoking? __________________How Long? ____________Quit how long ago?___________

How much alcohol do you drink? _____________________________Type? ______________________________

Family History Has any blood relative ever had the following:

	No	Yes		No	Yes		No	Yes
Breast Cancer			High Blood Pressure			Kidney Disease		
Melanoma			Heart Disease			Depression		
Stroke			Diabetes			Blood Clot		

Past Medical History Have you ever had the following:

	No	Yes		No	Yes		No	Yes
Heart Disease			Asthma			Thyroid Disease		
Arthritis			AIDS or HIV			Bleeding Tendency		
Anemia			Mitral Valve Prolapse			Stroke		
Diabetes			High Blood Pressure			Hepatitis		
Cancer (Type):			Stomach Ulcer			Blood Clots/DVT/PE		
Glaucoma			Kidney Disease					

Review of systems Do you have now or have had within the past year:

	No	Yes		No	Yes		No	Yes
Weight Change			Joint or Muscle Pain			Skin Rash		
Chronic Cough			Jaundice			Easy Bleeding		
Chest Pain			Depression			Easy Bruising		
Rapid Heart Beat			Seizures			History of sunburns		

Is there any possibility that you may be pregnant at this time? Yes No Number of pregnancies ____ Number of children____

List all surgeries that you have had (include plastic or cosmetic surgery), major illnesses or Hospital admissions with dates:

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Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems or unexpected fevers)? Yes No

Have you ever seen a cardiologist? Yes No Physician Name: ______________________________
Date of last EKG: ____

I verify that the above information is true and accurate to the best of my knowledge.

____ ____________________

Signature of patient or parent if minor Date