Aesthetic Plastic Surgery Associates, P.A.

Patient Medical History

Date: _____ Name: _____

Height: _____ Weight: _____ General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Allergies:

Drug/Latex/Substance	Type of Reaction
_____	_____
_____	_____

Please circle any of the following health conditions that apply to you:

High Blood Pressure Kidney Disease Stomach/Intestinal Disorder

Autoimmune Disease (i.e. **Lupus, Thyroid, Crohn's**) Bleeding Tendency

Phlebitis (Blood Clot) Diabetes Asthma/ Emphysema History MRSA

*Heart Murmur/ Arrhythmia * Heart Disease/ Stent Seizure/ Migraine Hepatitis/HIV

Sleep Apnea/ CPAP Musculoskeletal/Back/Neck Pain Dental History (loose teeth, dentures)

Do you use tobacco products? _____ How much/how often? _____

Do you use e-cigarettes/Vape? _____ How much/how often? _____

Do you consume alcohol? _____ How much/how often? _____

Please list all medications you are taking (prescription, NON-prescription, vitamins & herbs) and how often taken:

_____	_____
_____	_____
_____	_____

*Have you experienced chest pain, shortness of breath, coronary artery disease, cardiac stents? If yes, last visit with cardiologist?_____Results ?_____ Are you currently having any heart problems?_____

Please list any surgery or hospitalizations you have had:

_____	_____
_____	_____

Have you or any family members had a problem with anesthesia? _____ Describe_____

Have you been treated for an emotional disorder? _____ Disorder: _____

Are you pregnant? ☐ Yes ☐ No Trying to conceive: ☐ Yes ☐ No

If you are at least 60 years of age, when and where was your last EKG? _____