

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 mark 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? _____