

Aesthetic Plastic Surgery Associates

**Patient Medical History**

Date: \_\_/\_\_/\_\_\_\_ Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

General Health (circle one): 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 | Bleeding Tendency |
| Bleeding Tendency       | Autoimmune Disease (i.e. Lupus, Thyroid, Crohn's) | Seizure Migraine            |                   |
| Heart Murmur/Arrhythmia | Diabetes  | Phlebitis (Blood Clot)      | History MRSA      |
| Asthma/Emphysema        | Heart Disease/Stent                               | Hepatitis/HIV               |                   |

Do you use tobacco products? \_\_\_\_\_ How much/how often? \_\_\_\_\_

Do you consume alcohol? \_\_\_\_\_ How much/how often? \_\_\_\_\_

Do you take diet pills? \_\_\_\_\_ What type: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Please list any surgery or hospitalizations you have had:

\_\_\_\_\_  
\_\_\_\_\_

Have you been treated for an emotional disorder? \_\_\_\_\_ Disorder: \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ Trying to become pregnant? \_\_\_\_\_

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

\_\_\_\_\_