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 DiabetesPhlebitis (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? _____

_____