MARINA PLASTIC SURGERY ASSOCIATES

MEDICAL HISTORY

NAME_____ DATE_____

DATE OF YOUR LAST PHYSICAL EXAMINATION_____ WEIGHT_____ HEIGHT_____

SURGERY (OPERATIONS AND COSMETIC SURGERY):

	TYPE	DATE	COMPLICATIONS OR DIFFICULTIES
1.			
2.			
3.			
4.			
5.			
6.			

MEDICAL PROBLEMS OR CONDITIONS NOW UNDER TREATMENT BY A PHYSICIAN:

EXPLAIN:

_____

_____

_____

ADMISSIONS TO HOSPITAL:

	REASON	DATE	COMPLICATIONS OR DIFFICULTIES
1.			
2.			
3.			
4.			

MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS YOU TAKE NOW:

	TYPE	DOSAGE, AMOUNT IF KNOWN	TAKE HOW OFTEN
1.			
2.			
3.			
4.			

CONSUMPTION OF THE FOLLOWING:

ASPIRIN_____ AMOUNT DAILY_____ AMOUNT WEEKLY_____

ALCOHOL_____ AMOUNT DAILY_____ AMOUNT WEEKLY_____

TOBACCO_____ AMOUNT DAILY_____ AMOUNT WEEKLY_____

OTHERS_____ AMOUNT DAILY_____ AMOUNT WEEKLY_____

BLEEDING PROBLEMS:

DO YOU BRUISE OR BLEED EASILY?_____
(WITH CUTS? TOOTH EXTRACTION? PREGNANCY? SURGERY?)

EXPLAIN:
DO YOU HAVE A FAMILY HISTORY OF BLEEDING PROBLEMS?_____

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA:

EXPLAIN:

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES_____ NO_____

HAVE YOU EVER BEEN EXPOSED TO:

YES_____NO_____	INTRAVENOUS DRUGS	YES_____NO_____	HEPATITIS
YES_____NO_____	INFECTIOUS DISEASES	YES_____NO_____	HIV
YES_____NO_____	TB	YES_____NO_____	BLOOD TRANSFUSION
YES_____NO_____	AIDS	YES_____NO_____	LIVER TRANSPLANT

HISTORY OF EPILEPSY OR MENTAL ILLNESS:

EXPLAIN:

_____

CHILDHOOD MEDICAL HISTORY:

HAD ALL KNOWN "BABY SHOTS"? YES_____NO_____UNCERTAIN_____

HAD POLIO IMMUNIZATION? YES_____NO_____UNCERTAIN_____

HAD RHEUMATIC FEVER? YES_____NO_____UNCERTAIN_____

FAMILY HISTORY:

ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?

MOTHER _____ SISTER _____

_____ _____

FATHER _____ BROTHER _____

_____ _____

REVIEW OF SYSTEMS:

ANY MEDICAL PROBLEMS WITH ANY OF THE FOLLOWING?

NO_____ HEAD, IF YES EXPLAIN:

NO_____ EYES, IF YES EXPLAIN:

NO_____ EARS, NOSE, THROAT, IF YES EXPLAIN:

NO_____ THYROID, IF YES EXPLAIN:

NO_____ LUNGS, IF YES EXPLAIN:

NO_____ HEART, IF YES EXPLAIN:

NO_____ BLOOD PRESSURE OF VESSELS, IF YES EXPLAIN:

NO_____ DIGESTIVE SYSTEMS, IF YES EXPLAIN:

NO_____ LIVER, IF YES EXPLAIN:

NO_____ MUSCLES - BONES, IF YES EXPLAIN:

NO_____ REPRODUCTIVE ORGANS, IF YES EXPLAIN:

NO_____ KIDNEY'S - BLADDER, IF YES EXPLAIN:

NO_____ UNSIGHTLY SCARS, IF YES EXPLAIN:

NO_____ OTHER, IF YES EXPLAIN:

NO_____ DISEASE AFFECTING IMMUNE SYSTEM

ARE YOU PREGNANT?

YES_____NO_____

ALLERGIES:

ARE YOU ALLERGIC TO ANY MEDICATIONS? PLEASE LIST.

_____

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