THANK YOU FOR CHOOSING OUR PRACTICE!

Please take a moment to complete all information on this record. The information you provide is treated as confidential.

EAST LAKE
PLASTIC SURGERY CENTER

PATIENT HISTORY

Patient Name:____ Account #:___________

Date:________________Reason for your visit today:__________________________Date of Injury, If Applicable:___________

Please list current medical conditions (Heart problems, diabetes, bleeding disorder, etc):_________________________________

____

Medications currently taken on a regular basis (including over-the-counter and Herbals):________________________________

____

HAVE YOU **EVER** HAD:

□ ASTHMA	□ HIGH OR LOW BLOOD PRESSURE	□ LIVER DISEASE
□ LUNG PROBLEMS	□ RHEUMATIC FEVER	□ KIDNEY DISEASE
□ SHORTNESS OF BREATH	□ PAIN IN THE CHEST	□ DIABETES/ INSULIN USE
□ HEART MURMUR	□ PAIN IN THE ARMS	□ BLEEDING PROBLEMS
□ HEART DISEASE	□ DIZZINESS	□ BREAST DISEASE
□ HEART SURGERY	□ CONVULSIONS	□ GLAUCOMA

ARE YOU ALLERGIC TO:

□ FOODS ________	□ PENICILLIN	□ DEMEROL
□ SHELLFISH/ IODINE	□ OTHER ANTIBIOTICS	□ ANY ANESTHETIC________
□ ASPIRIN	□ CODEINE	□ NOVOCAINE/LIDOCAINE

Please list **any other allergies** not mentioned above:____

Have you ever had a general anesthetic before? □ Yes □ No If Yes, for what?____________________________________

Describe any problems you had with Anesthesia, if any:____

Do you smoke? □ Yes □ No If yes, how often?_______________________How many cigarettes per day?_________________

Do you use any other tobacco products? □ Yes □ No If yes, how often?____

Are you under the care of a physician at this time for any problem? □ Yes □ No If yes, please explain:_________________

COSMETIC SURGERY/PROCEDURE PATIENTS ONLY:

Have you ever consulted a plastic surgeon? □ Yes □ No For the same reason as today? □Yes □No

Have you had previous plastic surgery? □ Yes □ No

Have you ever been treated with Accutane (Isotretinoin) or any other acne medication? □ Yes □ No

WOMEN ONLY:

IS THERE A CHANCE YOU COULD BE PREGNANT NOW? □ YES □ NO

NURSING ONLY: AGE:_______HEIGHT:_________WEIGHT:_______T/P/R: ____________________ BP:_______

NURSING ONLY: AGE:_______ HEIGHT:_________ WEIGHT:________ T/P/R: _____________________ BP:________