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**Cosmetic Plastic Surgery**  
**Medical History**  
(Please Print Clearly)

Patient: \_\_\_\_\_

Date of Visit: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_  
(if different from Referring Physician above)

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Do you have any drug allergies? \_\_\_\_\_  
If so, please list:

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

Have you ever had any reactions to local anesthetics? Yes [ ] No [ ]  
If yes, please explain: \_\_\_\_\_

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

List all prescription and non-prescription medications you are currently taking:

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

Please check appropriate box if you have a history of, or are currently under treatment for, the following conditions (if any are "yes", please explain on lines below):

	Y	N		Y	N
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
X-Ray Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Ultra Violet Light Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Lung/Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Keloids	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
H I V	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint/Valve	<input type="checkbox"/>	<input type="checkbox"/>
Currently Pregnant/Nursing	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Condition	<input type="checkbox"/>	<input type="checkbox"/>
Accutane in past 12 months	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

Previous Surgery? If yes, explain type of surgery and give dates (mo/yr) of each surgery:

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Do you have a family history of melanoma? If yes, who in the family had melanoma (relationship)?

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Alcohol Use? How much and how often? \_\_\_\_\_

Tobacco Use? Types and amounts used per day? \_\_\_\_\_

\_\_\_\_\_  
Patient Signature (responsible party and relationship if patient is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date