

**THE COSMETIC AND RECONSTRUCTIVE SURGERY CENTER
MEDICAL HISTORY FORM**

Name _____ Age _____ Height _____ Weight _____

Are you in good Health? Yes No Currently under the care of a physician? Yes No

If yes, Doctor's name and Phone # _____

When was your last physical exam? _____ Was everything normal? Yes No

If no, please explain _____

Please list any known drug allergies _____

Other allergies _____

Please list all medications you are currently taking (including but not limited to birth control, over the counter medications, herbal remedies, and diet supplements):

Please list any current or past medical illness(es) including dates:

Please list all hospitalizations, injuries or accidents including dates:

Please list any surgeries (including cosmetic) including dates:

Have you ever had a bad surgical result? Yes No If yes, please explain:

Please list any significant hereditary disorders (i.e. excessive bleeding):

Do you exercise? Yes No If, yes what type? _____ How often? _____

Do you smoke? Yes No If yes, what type? _____ Frequency _____

Do you drink alcohol? () None () Occasionally () Moderately () Excessively

Do you have any problems with: gums, teeth, chronic nose or sinus complaints? Yes No

If yes, please explain _____

If female, are you currently pregnant or planning a pregnancy? Yes No

Please list below any other facts of a medical or other nature, which you feel, should be made known before you undergo surgery (if none, please write none)

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

To be completed by Physician: Additional Actions to be taken Prior to Surgery

() Medical Clearance Required From: () Cardiologist () Internist () Psychiatrist/Psychologist

() Additional tests Required: () EKG () Mammogram () SMAC Panel () Electrolytes

() Additional Medications Prior to Surgery _____

() Other _____

I have reviewed the Patient Medical History Form with the patient _____

Jeffrey C Friedman MD

PLEASE ANSWER THE FOLLOWING QUESTIONS

Comments

Do you have herpes or cold sore breakouts?	Yes	No
Do you have frequent headaches?	Yes	No
Do you have asthma or any chronic lung or bronchial condition?	Yes	No
Do you experience recurrent chest pain or shortness of breath?	Yes	No
Have you ever been told you have any trouble with your heart?	Yes	No
Do you have any abdominal problems: (stomach, intestinal, gallbladder, liver, hernia, hepatitis)?	Yes	No
Any trouble with your kidney's, bladder, or reproductive system?	Yes	No
Any bone joint or muscular trouble?	Yes	No
Do you have any chronic skin conditions?	Yes	No
Do you have any of the following: diabetes, epilepsy or high blood pressure?	Yes	No
Do you have AIDS, ARC or are you positive for the AIDS virus?	Yes	No
Have you ever had a nervous breakdown?	Yes	No
Have you ever been under the care of a psychiatrist or psychologist?	Yes	No
Have you had any marked loss or gain of weight lately?	Yes	No
Are you on a special diet at the present time?	Yes	No
Do you bleed or bruise easily?	Yes	No
Do your cuts seem to bleed longer than other peoples do?	Yes	No
Do the blood vessels in your skin sometimes break without apparent cause?	Yes	No
Do you have nosebleeds?	Yes	No
Have you ever had any bleeding requiring the attention of a doctor?	Yes	No
Have you ever had a blood transfusion?	Yes	No
Have you ever had excessive bleeding following surgery or dental work?	Yes	No
(FOR WOMEN) Do your periods last longer than 4 or 5 days?	Yes	No
Have you ever had poor scarring or keloid formation following an operation or vaccination?	Yes	No
Did you have a normal recovery following a prior surgery?	Yes	No
Are you extremely sensitive to anesthetics or any medicines?	Yes	No
Do you understand that no surgeon can guarantee a good result in any operation that he performs?	Yes	No
Do you understand that anyone undergoing any operation, no matter how minor, must assume a certain risks?	Yes	No
Have you ever been dissatisfied with the treatment you received from a doctor or dentist?	Yes	No
If yes, please explain _____		

Are you taking any of the following frequently, regularly or once in a while?

Comments

Allergy shots	Yes	No	Antibiotics	Yes	No
Antidepressants	Yes	No	Antihistamines	Yes	No
Arthritis medicine	Yes	No	Aspirin	Yes	No
Sleeping pills	Yes	No	Birth Control Pills	Yes	No
Blood Thinner	Yes	No	Blood Pressure Med.	Yes	No
Cortisone	Yes	No	Diabetes Medicine	Yes	No
Diet Pills	Yes	No	Diuretics (fluid Pills)	Yes	No
Eye Medicine	Yes	No	Headache Medicine	Yes	No
Heart Medicine	Yes	No	Hormones	Yes	No
Iron	Yes	No	Laxatives	Yes	No
Nose Drops	Yes	No	Pain Relievers	Yes	No
Thyroid Medicine	Yes	No	Stomach Medicine	Yes	No
Vitamins	Yes	No	Tranquilizers	Yes	No
List all medicines and dosages taken within the past two weeks:			Cholesterol meds.	Yes	No

Is there a history of any of the following conditions in your family?

Alcoholism	Yes	No	Allergies	Yes	No
Bleeding Tendencies	Yes	No	Cancer	Yes	No
Birth defects	Yes	No	Epilepsy	Yes	No
Heart Attacks	Yes	No	High Blood Pressure	Yes	No
Nervous Breakdown	Yes	No	Stomach Trouble	Yes	No
Strokes	Yes	No	Suicides	Yes	No

I have completed this form fully and completely, and certify that I am the patient or dully authorized agent of the patient authorized to Furnish the information requested.

Signature

Date