TRIBECA PLASTIC SURGERY

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MEDICAL HISTORY

TODAY'S DATE _____

NAME: _____ AGE: _____
LAST FIRST MIDDLE

PRIMARY CARE PHYSICIAN: _____
NAME CITY PHONE NUMBER

WHEN DID YOU LAST HAVE THE FOLLOWING? PHYSICAL EXAM: _____ EKG: _____

CHEST X-RAY: _____ BLOOD WORK: _____ T-CELL COUNT: _____

COSMETIC HISTORY: PLEASE LIST ALL **COSMETIC** SURGERIES & THE **SURGEONS** WHO PERFORMED THEM.

	NAME OF PROCEDURE	NAME OF SURGEON	DATE
1.)			
2.)			
3.)			
4.)			
5.)			

HAVE YOU EVER HAD ANY **INJECTABLE FILLERS** (RESTYLANE, RADIANCE, COLLAGEN, COSMODERM, SILICONE ETC) PLEASE LIST _____

TO WHAT AREAS? _____

DATE OF LAST INJECTION: _____ ANY PROBLEMS? _____

DESCRIBE YOUR HISTORY OF: SUN EXPOSURE: _____ SKIN CANCER: _____

ACNE: _____ OTHER SKIN PROBLEMS: _____

HAVE YOU EVER USED **RETIN-A**? **Y / N** IF YES: ARE YOU STILL USING IT? **Y / N**

WHAT OTHER SKIN CARE PRODUCTS ARE YOU CURRENTLY USING? _____

HAVE YOU EVER HAD A **BOTOX** INJECTION? **Y / N** WHAT AREAS? _____

DATE OF LAST INJECTION_____

NAME: _____
LAST FIRST MIDDLE

MEDICAL HISTORY: PLEASE LIST ALL HEALTH PROBLEMS (HIGH BLOOD PRESSURE, DIABETES, SEIZURE DISORDERS, ARTHRITIS, ETC.)? _____

NON-COSMETIC SURGICAL HISTORY AND/OR HOSPITALIZATIONS:

1.) _____ DATE: _____
2.) _____ DATE: _____
3.) _____ DATE: _____
4.) _____ DATE: _____

PLEASE LIST ALL CURRENT OR RECENT MEDICATIONS.

1.) _____ FREQUENCY: _____
2.) _____ FREQUENCY: _____
3.) _____ FREQUENCY: _____
4.)ASPIRIN OR IBUPROFEN PRODUCTS: _____
5.)VITAMINS/HERBS/SUPPLEMENTS: _____

PLEASE LIST ANY MEDICATIONS TO WHICH YOU HAVE HAD A REACTION:

1.) _____ 2.) _____ 3.) _____ 4.) _____

HAVE YOU EVER **SMOKED**? Y / N IF YES: DO YOU STILL SMOKE? Y / N

HOW MANY PACKS PER DAY? _____

AT WHAT AGE DID YOU START? _____ AT WHAT AGE DID YOU STOP? _____

DO YOU HAVE ANY PROBLEMS WITH BRUISING OR BLEEDING? _____

DO YOU HAVE A HEART MURMUR OR NEED TO TAKE ANTIBIOTICS BEFORE PROCEDURES? _____

HAVE YOU EVER HAD A PROBLEM WITH YOUR NERVES OR MUSCLES (STROKES, TEMPORARY PARALYSIS,

BELL'S PALSY, NERVE INJURIES, ETC.)? _____

DO ANY DISEASES RUN IN YOUR FAMILY? _____

HAVE YOU EVER BEEN TREATED FOR A PSYCHIATRIC ILLNESS? _____

DO YOU GET FEVER BLISTERS OR OTHER SORES ON YOUR LIPS? _____

DO YOU EXERCISE REGULARLY? IF SO, HOW? _____

WHAT IS YOUR HEIGHT? _____ CURRENT WEIGHT? _____ IDEAL WEIGHT? _____

OFFICE USE: BP _____ **Weight:** _____ **Nurse's Ins.** _____