Aesthetic, & Laser Plastic Surgery Center

Jamal Yousefi, M.D.
Board Certified Plastic Surgeon
Diplomat of American Society of Plastic Surgeons

PATIENT MEDICAL INFORMATION

PATIENT'S NAME____

WHAT SPECIFICALLY DO YOU WISH TO HAVE CORRECTED?____________________________

HOW LONG HAS THIS BEEN BOTHERING YOU?____________________________

GENERAL HEALTH: ________Good ________Fair ________Poor

PLEASE MAKE A CHECK MARK BESIDE ANY OF THE FOLLOWING MEDICAL ILLNESSES THAT YOU MAY HAVE :

__High Blood Pressure
__Diabetes (Type_______)
__Heart Problems
__Breathing Problems
__Kidney Problems
__Complications from Anesthesia
__Stomach Problems
__Bleeding Problems
__Thyroid Problems
__Mental Problems
__Keloids or Hypertopic Scars
__Cancer
__Anemia
__Eye Problems
__Neurological Disorders
__Rheumatic Fever
__Ulcers
__Mitral Valve Prolapse

WHEN WERE YOU LAST TESTED FOR HIV?________________ Positive/Negative results?

HAVE YOU EVER BEEN TREATED FOR ANY PSYCHIATRIC PROBLEMS? ________YES ________NO

HAVE YOU HAD ANY SURGERIES BEFORE?____________________________DATE OF SURGERY____________

HAVE YOU HAD ANY REACTION TO INJECTIONS OF LOCAL ANESTHESIA?_______YES _______NO

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?____________________________

ARE YOU TAKING VITAMIN "E"?________YES ________NO

DO YOU TAKE ASPIRIN OR ANY BLOOD THINNER? ________YES ________NO

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS? ________YES ________NO

If yes please list:____________________________

DO YOU SMOKE?___YES ___NO
HOW OFTEN DO YOU SMOKE?____________________________

HOW LONG HAVE YOU BEEN SMOKING FOR?____________________________

HOW OFTEN DO YOU DRINK ALCOHOL?____________________________

DO YOU HAVE A PRIMARY PHYSICIAN? ________YES ________NO