YOUNGER IMAGE

PLASTIC SURGERY CENTER

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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

WEIGHT: ____________ **HEIGHT:** ____________

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

__High Blood Pressure
__Diabetics (Type____)
__Heart Problem
__Breathing Problem
__Kidney Problem
__Complications from Anesthesia
__Stomach Problems
__Bleeding Problems
__Thyroid Problems
__ Mental Problems
__Keloids or Hypertopic Scars
__ Cancer
__Anemia
__Eye Problems
__Neurological Disorders
__Rheumatic Fever
__ Ulcer
__Mitral Valve Prolapse

WHEN WERE YOU LAST TESTED FOR HIV? ____________ **Positive/Negative result?**

HAVE YOU EVER BEEN TREATED FOR ANY PSYCHIATRIC PROBLEM? ______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

____________________ ____________________
Signature *Date*