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Plastic Surgery Centre

MEDICAL HISTORY

Name: _____

Who may we thank for your referral? _____

Family Physician: _____

Reason for visit: _____

Current medical conditions (diabetes, heart problems, etc): _____

Medications taken on a regular basis: _____

Have you EVER taken or been treated with Accutane? YES NO

Have you ever had:

- HEART MURMUR
- HEART DISEASE
- HEART SURGERY
- RHEUMATIC FEVER
- LUNG TROUBLE
- SHORTNESS OF BREATH
- SWELLING OF ANKLES
- BLEEDING PROBLEMS
- HIGH OR LOW BLOOD PRESSURE

- JAUNDICE
- CONVULSIONS
- DIZZINESS
- DIABETES/TAKEN INSULIN
- KIDNEY DISEASE
- PAIN IN CHEST
- PAIN IN ARMS
- ASTHMA

Are you allergic to:

- PENICILLIN
- ASPIRIN
- CODEINE
- DEMEROL
- ANESTHETIC/NOVOCAINE
- ANY FOODS
- OTHER DRUG/MEDICATION
- DO YOU WEAR CONTACTS

Please list any allergies not mentioned above: _____

Do you smoke? YES NO How Often? _____ How many cigarettes? _____

Have you ever had a general anesthetic before? YES NO For What? _____

Describe any problems: _____

If you are under the care of a physician at this time, please state the nature of the problem: _____

Are you taking any pills, or other medications at this time? _____

Is there anything about your physical condition that should be called to the Dr's attention? _____

Have you ever consulted a plastic surgeon? YES NO

Have you had previous plastic surgery? YES NO