Mission Plastic Surgery

Allen M. Doezie, M.D.

Patient Name: ________________________________ **Date:** __________________
DOB: ______________________ **Age**: _____ **Weight**: ________ **Height**: ____ **ft** ___**in**

Please list all medical problems:

____

____

****Are you allergic to any medications?** □Yes □ No
If yes, please list: ____

Do you take birth control pills? □Yes □ No

Please list all medications you are currently taking:

____

____

Do you smoke? □Yes □No If yes, how many packs a week? _________
Do you drink alcohol? □Yes □No If yes, how many glasses per week? ______
Recreational Drugs? □Yes □No What type of drugs? ___________________

Please list all medical problems in immediate family members:

____

Family history of breast cancer? □Yes □ No In Whom? ______________________

Have you ever had: ____

- □ Chest pain
- □ Heart attacks
- □ Heart murmurs
- □ Congenital heart problems
- □ Mitral valve prolapse
- □ Pacemaker
- □ High blood pressure
- □ Asthma
- □ Emphysema
- □ History of pneumonia
- □ Diabetes
- □ Hypothyroidism
- □ Hyperthyroidism
- □ Seizures / Epilepsy
- □ Stroke
- □ Blood clots
- □ Bleeding disorders
- □ Anemia
- □ Sickle cell disease
- □ Hepatitis (If yes, what type/_______)
- □ Jaundice
- □ Liver disease
- □ Gastroesophageal reflux
- □ Kidney disease
- □ Frequent bladder infections
- □ Cancer
- □ Radiation treatment
- □ Psychiatric care
- □ Herpes
- □ HIV
- □ Current tooth abscess / infection

Please list all previous surgeries:___

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Females Only:
Number of children:____________
Ages: ______________
Vaginal or C-Section?_________

Other comments:____
Patient Signature:_______________________________________ **Date**: ___________