Mission Plastic Surgery

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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/vape? Yes No If yes, how much per 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 (please circle):

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 (What type?____)
Jaundice
Liver disease
Gastroesophageal reflux
Kidney disease
Frequent bladder infections
Cancer
Radiation treatment
Psychiatric care
Herpes
HIV
Current tooth abscess/infection

<u>For Females:</u>
Number of children:_____
Ages:_____
Vaginal or C-Section? (Circle)

Please list all previous surgeries:

_____