MARINA PLASTIC SURGERY

MEDICAL HISTORY

NAME _____ DATE _____

DATE OF YOUR LAST PHYSICAL EXAMINATION _____ WEIGHT _____ HEIGHT _____

SURGERY (OPERATIONS AND COSMETIC SRUGERY)

TYPE DATE COMPLICATIONS OR DIFFICULTIES

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MEDICAL PROBLEMS OR CONDITIONA NOW UNDER TREATMENT BY A PHYSICIAN

EXPLAIN _____

_____

_____

ADMISSIONS TO HOSPITAL

REASON DATE COMPLICATIONS OR DIFFICULTIES

1. _____
2. _____
3. _____
4. _____

MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS YOU TAKE NOW

TYPE DOSAGE/AMOUNT IF KNOWN TAKE HOW OFTEN

1. _____
2. _____
3. _____
4. _____

CONSUMPTION OF THE FOLLOWING

ASPIRIN _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

ALCOHOL _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

TOBACCO _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

OTHERS _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

BLEEDING PROBLEMS

DO YOU BRUISE OR BLEED EASILY? YES NO (WITH CUTS / TOOTH EXTRACTIONS / PREGNANCY / SURGERY)

EXPLAIN _____

DO YOU HAVE A FAMILY HISTORY OF BLEEDING PROBLEMS? EXPLAIN _____

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA

EXPLAIN _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO

ARE YOU PREGNANT? YES NO

HAVE YOU EVER HAD, HAVE OR BEEN EXPOSED TO (PLEASE CIRCLE YES OR NO)

YES	NO	INTRAVENOUS DRUGS	YES	NO	HEPATITIS
YES	NO	INFECTIOUS DISEASES	YES	NO	HIV /AIDS
YES	NO	TB	YES	NO	LIVER TRANSPLANT

IF YES TO ANY EXPLAIN _____

_____

HISTORY OF EPILEPSY OR MENTAL ILLNESS

EXPLAIN_____

_____

CHILDHOOD MEDICAL HISTORY (PLEASE CIRLE YES, NO OR UNCERTAIN)

HAD ALL KNOWN "BABY SHOTS"?	YES	NO	UNCERTAIN
HAD POLIO IMMUNIZATION?	YES	NO	UNCERTAIN
HAD RHEUMATIC FEVER?	YES	NO	UNCERTAIN

FAMILY HISTORY

ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?

MOTHER_____ SISTER_____

_____ _____

FATHER_____ BROTHER_____

_____ _____

OTHER RELATIVE:_____

REVIEW OF SYSTEMS

ANY MEDICAL PROBLEMS WITH ANY OF THE FOLLOWING:

NO_____ HEAD, IF YES EXPLAIN_____

NO_____ EYES, IF YES EXPLAIN_____

NO_____ EARS, IF YES EXPLAIN_____

NO_____ THYROID, IF YES EXPLAIN_____

NO_____ LUNGS, IF YES EXPLAIN_____

NO_____ HEART, IF YES EXPLAIN_____

NO_____ BLOOD PRESSURE OR VESSELS, IF YES EXPLAIN_____

NO_____ DIGESTIVE SYSTEMS, IF YES EXPLAIN_____

NO_____ LIVER, IF YES EXPLAIN_____

NO_____ MUSCLES-BONES, IF YES EXPLAIN_____

NO_____ REPRODUCTIVE ORGANS, IF YES EXPLAIN_____

NO_____ KIDNEY'S-BLADDER, IF YES EXPLAIN_____

NO_____ UNSIGHTLY SCARS, IF YES EXPLAIN_____

NO_____ OTHER, IF YES EXPLAIN_____

NO_____ DISEASE AFFECTING IMMUNE SYSTEM, IF YES EXPLAIN_____

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATION(S)? PLEASE LIST

_____

_____

_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PRACTICE NAME:_____

PHYSICIAN:_____

ADDRESS:_____

BY REPRESENTATION OF SIGNATURE BELOW, I HEREBY AUTHORIZE THE ABOVE STATED OFFICE TO FORWARD MY MEDICAL RECORDS TO:

MARINA PLASTIC SURGERY ASSOCIATES
4644 LINCOLN BLVD, SUITE 552
MARINA DEL REY, CA 90292
PHONE: 310.827.2653 * FAX : 310.823.1984

_____ _____

PATIENT SIGNATURE DATE