Inspired by your Inner Beauty

PERIMETER PLASTIC SURGERY

PATIENT NAME: ____________________________ HEIGHT: ____________ WEIGHT: _____________

Do you have or have you ever had the following (Please check and give date of occurrences):

☐ AIDS or HIV	☐ Congenital Heart Disease ☐ Rheumatic Heat Disease	☐ Blood Disorders • Anemia • Leukemia • Blood Clots/DVTs • Bleeding Tendencies	☐ Migraines
☐ Arthritis or Rheumatic Disorders	☐ Diabetes	☐ Hepatitis	☐ Mental Illness
☐ Asthma	☐ Epilepsy or Seizures	☐ High Blood Pressure	☐ Visual Problems ☐ Hearing Problems
☐ Back Problems	☐ Gastrointestinal Disease • Colitis • Crohn's Disease • IBS	☐ Stroke	☐ Gastric Reflux ☐ Stomach Ulcers
☐ COPD: Chronic bronchitis or emphysema	☐ Kidney Disease or Stones	☐ Tuberculosis	☐ Thyroid Disease
☐ Cancer Type: ____________	☐ Hepatitis	☐ Heart Attack	☐ Skin Disorders

Do you know of any blood relatives who have or have had any of the above? Please explain:

____

Do you have any other serious illness(es) not listed above? Please explain: ______________________________

____

Please list any operations you have had along with the date of the procedure:

Have you or a family member ever had a complication from anesthesia? Y or N Please explain: ___________________

____

Do you smoke? Y or N How many packs per day? ______
Did you smoke in the past? Y or N When did you quit? ______
How many caffeinated beverages do you consume per day? ______ Alcoholic beverages per day? ______

Please list any medication(s) you are taking along with their dosages:

Are you taking any of the following medications? Please circle:

Ibuprofen products or Aspirin *Herbal medications or teas* *Diet Medications* *Blood Thinners* *Vitamins* *Birth Control Pills*

Do you have any medical or religious reasons for denying a blood transfusion? Y or N

Are you allergic to any medications, latex products, adhesives or betadine? Please list: ___________________________

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WOMEN ONLY: Date of last mammogram: _______________ Results: _____________________________________
How many biological children do you have? ____; Could you be pregnant? Y or N

____ _______/_______/_________

SIGNATURE OF PATIENT OR RESPONSIBLE PERSON **DATE**