Reveal Beauty Plastic Surgery

PATIENT MEDICAL HISTORY

(This information is protected by the Health Insurance Portability and Accountability Act)

Legal Name: _____ **Preferred Name/Pronoun:** _____ **Age:** _____

Reason For Visit: _____ **Sex:** M ☐ F ☐ **Ht:** _____ **Wt:** _____

Daily Medications: (Name and Dosage; please include vitamins, nutritional supplements, diet pills, and chronic steroid use such as Prednisone)

_____

_____

Drug Allergies: Name & Type of Reaction; _____

_____ **If Allergic to Penicillin, can you take Keflex?** _____

Previous Surgery (Type & Date): _____

_____ **Have you had any abdominal surgeries? YES / NO**

PAST MEDICAL HISTORY:	Please check YES or NO	Yourself		Family Members		Relationship
Heart Disease (heart attack, heart failure abnormal rhythm)		yes ____	no ____	yes ____	no ____	_____
Mitral Valve Prolapse		yes ____	no ____	yes ____	no ____	_____
Asthma		yes ____	no ____	yes ____	no ____	_____
Diabetes		yes ____	no ____	yes ____	no ____	_____
Hypertension (high blood pressure)		yes ____	no ____	yes ____	no ____	_____
Hepatitis		yes ____	no ____	yes ____	no ____	_____
Jaundice		yes ____	no ____	yes ____	no ____	_____
Malignant Hyperthermia		yes ____	no ____	yes ____	no ____	_____
Seizures		yes ____	no ____	yes ____	no ____	_____
Bleeding Tendency		yes ____	no ____	yes ____	no ____	_____
Deep Vein Thrombosis		yes ____	no ____	yes ____	no ____	_____
Pulmonary Embolism		yes ____	no ____	yes ____	no ____	_____
Glaucoma		yes ____	no ____	yes ____	no ____	_____
Cancer		yes ____	no ____	yes ____	no ____	_____
Adverse Reaction to Anesthesia (if yes, give details)		yes ____	no ____	yes ____	no ____	_____

_____

Please list any other illness that required surgery, hospitalization or chronic treatment: _____

_____

FOR WOMEN ONLY:

Breast Cancer History: Self? _____ **Mother or Sister?** _____

Pregnancies: How many _____ **Type of delivery** _____ **Ages of children** _____

If considering breast surgery: Current Bra size _____ **Desired size** _____

Date of last Mammogram _____ **Results** _____

Do you smoke/vape? **Yes / No** If yes, how much per day? _____ Would you be willing to stop smoking/vaping for a period of four weeks prior and four weeks after your surgery? **Yes / No**

Do you drink alcoholic beverages? **Yes / No** If yes, how much? _____

Do you use any illicit drugs? **Yes / No** If yes, please describe: _____

I attest that the information I have provided above is correct, complete and current, realizing that the medical care provided to me may be based on this information. _____ **Date:** _____

Signature Required