Cosmetic Surgery
OF NEW YORK PC

PATIENT INFORMATION

Patient's Name: _____ Date: _____

Your Name: _____ Relationship: _____

Your family Physician: _____

Brief history of the problem or concern: _____

_____

Have you seen another physician about this problem? _____

Height: _____ Weight: _____ Blood Pressure: _____/_____

Medications taken routinely, including over the counter, diet and herbal supplements
Aspirin, Motrin, Accutane, Serzone etc. _____

_____

Drug Allergies: _____

Illegal Drug Use: ___ Yes ___ No

Alcohol Use: ____ Socially ___ Daily ___ Do not use

Do you smoke now? _____ ? # Per day _____

Smoking is hazardous to your health and wound healing and can result in skin and/or tissue loss, poor wound healing and other complications. You are advised not to smoke for at least 2 weeks before or after your surgery.

List all previous surgeries **with dates**. Include all cosmetic surgery and injuries:_____

_____

_____

MEDICAL HISTORY Have you ever had, or been treated for:

- ☐ None of the conditions listed below
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Heart trouble
- ☐ Tumors, benign or malignant [cancer]
- ☐ Low blood count, anemia, bleeding
- ☐ Bleeding tendency
- ☐ Mental or emotional problems
- ☐ Breathing problems, short of breath
- ☐ Asthma
- ☐ Urinary tract or kidney disease
- ☐ Fractures, scoliosis, back trouble
- ☐ Pacemaker/Defibrilator
- ☐ Other
- ☐ Endocrine or thyroid disease
- ☐ High Blood Pressure
- ☐ Congenital heart disease
- ☐ Stroke
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Eye or ear problems
- ☐ Leukemia
- ☐ Neurologic disease, epilepsy, seizures
- ☐ Gastrointestinal problems
- ☐ Implant of any kind

☐ Family History of: _____

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