BLOOMFIELD PLASTIC SURGERY

Health Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: _____Reason for Visit:_____

Age:_____ Height::_____Feet :_____Inches Weight:_____Lis.

Referring Physician(s): _____

Date of Last Physical Examination: _____

List all Surgeries (Hospitalization and the Date of Occurrence):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Heart Trouble/Heart Disease	No	Yes	Kidney Problems	No	Yes
HIV/Aids	No	Yes	Auto-Immune Disease	No	Yes
Asthma/Breathing Problems	No	Yes	Sinus Problems/Infections	No	Yes
Bronchitis/Pneumonia	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Herpes/Cold Sores	No	Yes
Depression/Psychiatric Care	No	Yes	Tuberculosis	No	Yes
Diabetes	No	Yes	Ulcers	No	Yes
Dizziness/Vertigo	No	Yes	Alcoholism/Drug Dependency	No	Yes
Epilepsy/Seizures	No	Yes	Family History of Cancer	No	Yes
Palsy or Paralysis	No	Yes	Eye Problems	No	Yes
Rheumatic Fever	No	Yes	Breast Cysts, Tumors, Abscesses	No	Yes
Goiter/Thyroid	No	Yes	High Blood Pressure	No	Yes
Hay Fever/Allergies	No	Yes	Blood Transfusion	No	Yes
Headaches/Migraine	No	Yes	Arthritis	No	Yes
Piercing other than ears	No	Yes	Fracture of Neck or Spine	No	Yes
Hepatitis	No	Yes			

PLEASE COMPLETE OTHER SIDE

Do you smoke? No Yes If yes, how much? _____ Pack(s)/day How long? _____ Years

Do you drink alcohol? No Yes If yes, how much? _____ How often?_____

Do you use recreational drugs or have a history of drug dependency? No Yes If yes, describe:_____

Do you have bleeding or bruising problems? No Yes If yes, describe:_____

Do you have problems with scarring? No Yes If yes, describe:_____

Do you or any family members have any history of problems with anesthesia? No Yes If yes, describe:_____

Are you or could you be pregnant? No Yes

Which is your dominant hand? Left Right

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

List ALL drug and/or latex allergies.

Name, Address and Telephone Number of Pharmacy.

The above information is accurate and complete to the best of my knowledge.

Signature _____Date_____