Coastal Plastic Surgery

MEDICAL INFORMATION (**Please fill in all blanks**)

Name of Patient:_____Date_____

Reason for Consultation:_____

Age:_____Height:_____Weight:_____Blood Type:_____ Ethnicity:_____

Date of Last Physical Examination:_____ Currently Under Medical Treatment? : **Y** / **N**

Serious Illness's/Hospitalizations: (Past/Present)_____

_____

Previous Surgeries:(Date/Procedures/Physician)_____

Serious Injuries/Accidents:(Date/Physician)_____

_____

Please list all medications (prescriptions /non-prescription / herbal), you are currently taking or take on a routine basis:

_____

_____

Some medications/ vitamins/ herbal supplements affect bleeding. Do you take any of the following: Vitamin E: **Y / N**

Aspirin/aspirin products: **Y / N** Ibuprofen: **Y / N** Green tea: **Y / N** How often _____

List Any Medication Allergies: _____

Codeine_____Sulfa_____Morphine_____Penicillin_____'Mycins_____Tetracyclin_____

Are you allergic to any topical preparations? Tape_____Betadine_____Latex_____Others:_____

Hereditary Disorders:(e.g.Clotting/Bleeding Disorders, Diabetes, Cancer, Hypertension, Heart Disease, etc.)_____

_____

Family History (medical problems or illnesses):_____

_____

Do you smoke? **Y / N** If yes, how long and how much?_____ Quit date:_____

Do you drink alcohol? **Y / N** If yes, how often and how much? _____

Emergency Contact:_____ Phone Number:_____

Family Physician/ PCP:_____ Phone_____

Pharmacy (Name/ Location):_____ Phone_____