Burt and Will Plastic Surgery and Laser Centre

Date:_____

## MEDICAL HISTORY

**Patient Name** _____ **DOB** _____ **Age** _____

**Reason for Visit:** _____

**Referring Physician:** _____

Address: _____

City: _____ State : _____ Zip: _____

Height _____ Weight _____ Weight loss or gain in the past year? Y / N

Amount of weight: Loss _____ Gain _____

When was your most recent physical check-up? _____

**Medical Conditions: Please mark all that apply**

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Chronic Lung Disease

Other: _____

| Medications | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Are you allergic to any medications? None

| Drug | Reaction |
|---|---|
| | |
| | |

| Surgeries & Hospitalization History | Dates |
|---|---|
| | |
| | |
| | |

Are you interested in any of the following procedures?

| | | | | |
|---|---|---|---|---|
| Rhinoplasty | Eyelid Surgery | Liposuction | Botox | Chemical Peels |
| Face Lift | Brow Lift | Abdominoplasty | Facial Fillers | Laser Treatments |
| | Breast: Augmentation/ Lift/ Reduction | | | |

**Would you like to learn more about our full-service spa, Limelight Medspa & Cosmetic Laser Centre?**

(Conveniently located next to our offices)

Yes No

*Burt and Will Plastic Surgery and Laser Centre*

**Patient Name:** _____

**Occupation:** _____

**Social History:**

Please indicate daily consumption or prior history of each of the following:

Tobacco _____

Alcohol _____

**Family History:** Mark all that apply

___Heart Disease ___Diabetes

___High Blood Pressure ___Mental Disease

___Stroke ___Cancer

Other: _____

_____

**Pertinent Preoperative Information:**

| | | |
|---|---|---|
| Have you ever reacted badly to being put to sleep for surgery? | No ___ | Yes ___ |
| Has any member of your family ever reacted badly to being put to sleep for surgery? | No ___ | Yes ___ |
| Have you required large amounts of local anesthetic for medical or dental procedures? | No ___ | Yes ___ |
| Have you ever had a bad reaction to local anesthetic (Novocain, etc.)? | No ___ | Yes ___ |
| Are you allergic to adhesive tape? | No ___ | Yes ___ |
| Have you ever had Scarlet fever or Rheumatic fever? | No ___ | Yes ___ |
| Do you have high blood pressure? | No ___ | Yes ___ |
| Do you bleed unusually easily (from cuts, surgery, tooth extractions)? | No ___ | Yes ___ |
| Do you bruise easily? | No ___ | Yes ___ |
| Have you required transfusion for surgery? | No ___ | Yes ___ |
| Are you a slow or poor healer? | No ___ | Yes ___ |
| Do you form large scars or keloids? | No ___ | Yes ___ |
| Do you have any skin disease, hives, eczema or rashes? | No ___ | Yes ___ |
| Do you have frequent infections or boils? | No ___ | Yes ___ |
| Have you taken steroid medications, cortisone, or ACTH? | No ___ | Yes ___ |
| Do you have shortness of breath with walking? | No ___ | Yes ___ |
| Do you have chest pain? | No ___ | Yes ___ |
| Does your religion prohibit blood transfusions? | No ___ | Yes ___ |
| Do you have, or have you had any significant emotion problems? | No ___ | Yes ___ |
| Have you ever been advised to see a psychiatrist? | No ___ | Yes ___ |
| Are you pregnant? | No ___ | Yes ___ |
| Have you had a mammogram? | No ___ | Yes ___ |

If yes, when ? _____