

Coastal Plastic Surgery

MEDICAL INFORMATION (Please fill in all blanks)

Name of Patient: _____ Date _____

Reason for Consultation: _____

Age: _____ Height: _____ Weight: _____ Blood Type: _____ Ethnicity: _____

Serious Illness's: (Past/Present) _____

Previous Surgeries:(Date/Procedures/Physician) _____

Serious Injuries/Accidents:(Date/Physician) _____

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

Do you take aspirin: No _____ Yes _____ If Yes,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 Disorders, Diabetes, Cancer, Hypertension Heart Disease, etc.) _____

Do you smoke? No _____ Yes _____ If yes, how long and how much? _____

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

Family Physician: _____ Phone _____

Pharmacy (Name/ Location): _____ Phone _____