Medical History

Height:_____Weight:_____Family Physician_____

Previous Cosmetic Surgery:_____

Prior Surgery/Hospitalizations:_____

_____

List your medications, exact dosages, and how often taken:

_____

_____

List your allergies, age of onset of allergy, and specify the exact type of allergic reaction:

_____

_____

Do you smoke? (circle one) Yes No If yes, how much?_____

Have you ever smoked? Yes No If yes, when did you quit?_____

Personal Medical History (identify relevant history with an "x")

Blood/Bleeding Disorders_____Genital/Urinary Disorders_____Heart Disease_____

High Blood Pressure_____Kidney Disease_____Liver Disease_____

Lung Disease_____Neurological Disorder_____Diabetes_____

Venereal Disease_____Asthma_____Hepatitis_____

Cancer_____Ulcers_____HIV_____

Growths_____Tumors_____Anesthesia Concerns_____

Please describe fully any positive responses:_____

_____

_____

Specify any significant FAMILY Medical History (list relationship of family member and specific diagnosis-be as exact as possible):_____

_____

_____