

MARINA PLASTIC SURGERY

MEDICAL HISTORY

NAME _____ DATE _____

DATE OF YOUR LAST PHYSICAL EXAMINATION _____ WEIGHT _____ HEIGHT _____

SURGERY (OPERATIONS AND COSMETIC SURGERY)

TYPE	DATE	COMPLICATIONS OR DIFFICULTIES
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

MEDICAL PROBLEMS OR CONDITIONS NOW UNDER TREATMENT BY A PHYSICIAN

EXPLAIN _____

ADMISSIONS TO HOSPITAL

REASON	DATE	COMPLICATIONS OR DIFFICULTIES
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS YOU TAKE NOW

TYPE	DOSAGE/AMOUNT IF KNOWN	TAKE HOW OFTEN
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

CONSUMPTION OF THE FOLLOWING

ASPIRIN _____	AMOUNT DAILY _____	AMOUNT WEEKLY _____
ALCOHOL _____	AMOUNT DAILY _____	AMOUNT WEEKLY _____
TOBACCO _____	AMOUNT DAILY _____	AMOUNT WEEKLY _____
OTHERS _____	AMOUNT DAILY _____	AMOUNT WEEKLY _____

BLEEDING PROBLEMS

DO YOU BRUISE OR BLEED EASILY? YES NO (WITH CUTS / TOOTH EXTRACTIONS / PREGNANCY / SURGERY)

EXPLAIN _____

DO YOU HAVE A FAMILY HISTORY OF BLEEDING PROBLEMS? EXPLAIN _____

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA

EXPLAIN _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO

ARE YOU PREGNANT? YES NO

HAVE YOU EVER HAD, HAVE OR BEEN EXPOSED TO (PLEASE CIRCLE YES OR NO)

YES	NO	INTRAVENOUS DRUGS	YES	NO	HEPATITIS
YES	NO	INFECTIOUS DISEASES	YES	NO	HIV / AIDS
YES	NO	TB	YES	NO	LIVER TRANSPLANT

IF YES TO ANY EXPLAIN _____

HISTORY OF EPILEPSY OR MENTAL ILLNESS

EXPLAIN _____

CHILDHOOD MEDICAL HISTORY (PLEASE CIRLE YES, NO OR UNCERTAIN)

HAD ALL KNOWN "BABY SHOTS"? YES NO UNCERTAIN
HAD POLIO IMMUNIZATION? YES NO UNCERTAIN
HAD RHEUMATIC FEVER? YES NO UNCERTAIN

FAMILY HISTORY

ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?

MOTHER _____

SISTER _____

FATHER _____

BROTHER _____

OTHER RELATIVE: _____

REVIEW OF SYSTEMS

ANY MEDICAL PROBLEMS WITH ANY OF THE FOLLOWING:

NO _____ HEAD, IF YES EXPLAIN _____

NO _____ EYES, IF YES EXPLAIN _____

NO _____ EARS, IF YES EXPLAIN _____

NO _____ THYROID, IF YES EXPLAIN _____

NO _____ LUNGS, IF YES EXPLAIN _____

NO _____ HEART, IF YES EXPLAIN _____

NO _____ BLOOD PRESSURE OR VESSELS, IF YES EXPLAIN _____

NO _____ DIGESTIVE SYSTEMS, IF YES EXPLAIN _____

NO _____ LIVER, IF YES EXPLAIN _____

NO _____ MUSCLES-BONES, IF YES EXPLAIN _____

NO _____ REPRODUCTIVE ORGANS, IF YES EXPLAIN _____

NO _____ KIDNEY'S-BLADDER, IF YES EXPLAIN _____

NO _____ UNSIGHTLY SCARS, IF YES EXPLAIN _____

NO _____ OTHER, IF YES EXPLAIN _____

NO _____ DISEASE AFFECTING IMMUNE SYSTEM, IF YES EXPLAIN _____

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATION(S)? PLEASE LIST

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PRACTICE NAME: _____

PHYSICIAN: _____

ADDRESS: _____

BY REPRESENTATION OF SIGNATURE BELOW, I HEREBY AUTHORIZE THE ABOVE STATED OFFICE TO FORWARD MY MEDICAL RECORDS TO:

MARINA PLASTIC SURGERY ASSOCIATES
4644 LINCOLN BLVD, SUITE 552
MARINA DEL REY, CA 90292
PHONE: 310.827.2653 * FAX : 310.823.1984

PATIENT SIGNATURE

DATE

PRINTED NAME