ASSOCIATES IN
Plastic Surgery
Est.1978

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Confidential Record

Information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in decisions regarding your care.

Name: _____ _____ _____
Last First Middle

Age _____ Ht. _____ Wt. _____ Sex _____ Marital Status: ☐ S ☐ M ☐ W ☐ Divorced or Separated

Date of Last Physical Examination _____ Physician's Name _____

Family or Referring Physician _____ Address & Phone No. _____

DO YOU HAVE OR HAVE YOU HAD: (Check Box/s Below)

	YES	NO		YES	NO		YES	NO
Stroke	☐	☐	Hay Fever	☐	☐	Keloids / Thick Scars	☐	☐
Cancer	☐	☐	Colitis	☐	☐	Rheumatic Heart	☐	☐
Tuberculosis	☐	☐	Goiter	☐	☐	Bleeding Tendency	☐	☐
Leukemia	☐	☐	Mitral Valve Prolapse	☐	☐	High Blood Pressure	☐	☐
Bronchitis	☐	☐	Sleep Apnea with or			Congenital Heart Disease	☐	☐
Epilepsy	☐	☐	without CPAP machine	☐	☐	Nervous Breakdown	☐	☐
Pneumonia	☐	☐	Bladder Infection	☐	☐	Dizziness / Fainting	☐	☐
Diabetes	☐	☐	Asthma	☐	☐	AIDS	☐	☐
Arthritis	☐	☐	Heart Attack	☐	☐	Sickle Cell Disease	☐	☐
Depression	☐	☐	Stomach Ulcers	☐	☐	Latex Allergies	☐	☐
Hepatitis / Jaundice	☐	☐	Kidney Disease	☐	☐	Deep Venous Thrombosis	☐	☐
Migrane	☐	☐	Tonsilitis	☐	☐			

What procedure are you interested in? _____

	YES	NO	
Do you wear dentures?	☐	☐	
Do you smoke?	☐	☐	How much? _____ How many years? _____
Do you drink alcohol or beer regularly?	☐	☐	How much? _____
Date of Last Chest X-ray _____			Date of Last EKG _____