LauferInstitute
of Plastic Surgery

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MEDICAL HISTORY

Name: ____ Email: ____

Who may we thank for your referral? ____

Family Physician: ____

Reason for visit: ____

Current Medical Conditions (diabetes, heart problems, etc.): ____________________________________

____

____

Medications taken on a regular basis: ____

____

Have you EVER taken or been treated with Accutane? ☐ Yes ☐ No

Have you ever had?		**Are you Allergic to?**
☐ HEART MURMUR	☐ JAUNDICE	☐ PENICILLIN
☐ HEART DISEASE	☐ CONVULSIONS	☐ ASPIRIN
☐ HEART SURGERY	☐ DIZZINESS	☐ CODEINE
☐ RHEUMATIC FEVER	☐ DIABETES/TAKEN INSULIN	☐ DEMEROL
☐ LUNG TROUBLE	☐ KIDNEY DISEASE	☐ ANESTHETIC/NO
☐ SHORTNESS OF BREATH	☐ PAIN IN CHEST	☐ ANY FOODS
☐ SWELLING OF ANKLES	☐ PAIN IN ARMS	☐ OTHER DRUG/MEDICATION
☐ HIGH OR LOW BLOOD PRESSURE	☐ ASTHMA	☐ DO YOU WEAR CONTACTS

Please list ANY ALLERGIES not mentioned above: ____

____

Do you SMOKE? ☐ YES ☐ NO How often? ________________ How many cigarettes per day? __________________

Have you ever had general anesthetic before? ☐ YES ☐ NO For what? _____________________________________

Describe any problems: ____

If you are under the care of a physician at this time, please state the nature of the problem: __________________

____

Are you taking any pills, or other medications at this time? ____

____

Is there anything about your physical condition that should be called to the Doctor's attention? ________________

____

Have you ever consulted a plastic surgeon? ☐ YES ☐ NO if yes, who? _______________________________________

Have you had previous plastic surgery? ☐ YES ☐ NO if yes, what? ____