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Medical History

Plastic surgeons need a full picture of your health to plan safely. Please complete every section — if something doesn't apply, write "N/A."

Patient Name: _____ Date: _____

Allergies

Do you have any drug allergies? ☐ Yes ☐ No Are you allergic to Latex? ☐ Yes ☐ No _____

Please list ALL drug allergies and the reaction (write "none" if you have no allergies):

Drug Allergy	Reaction

Medical Conditions

Please list any current or ongoing medical conditions:

_____

Height: _____ Weight: _____ Are you at your preferred weight? _____

Health Questionnaire

Please answer all of the following:

Blood thinners / aspirin? ☐Y ☐N	Antibiotics before procedures? ☐Y ☐N
Pacemaker or defibrillator? ☐Y ☐N	History of cold sores? ☐Y ☐N
Coughing / shortness of breath? ☐Y ☐N	Breathing problems? ☐Y ☐N
Joint pain? ☐Y ☐N	Take or have taken GLP's? ☐Y ☐N
Chest pain? ☐Y ☐N	Asthma? ☐Y ☐N
Prior problem with anesthesia? ☐Y ☐N	Infectious disease (HIV, Hep B/C, TB)? ☐Y ☐N
Diabetes? ☐Y ☐N	High blood pressure? ☐Y ☐N
History of cancer? ☐Y ☐N	Take fish oil / supplements? ☐Y ☐N

If cancer, type: _____ Recent mammogram date (if applicable): _____

Patient Name: _____

Lifestyle

Tobacco & Nicotine

Do you currently or have you in the past used tobacco or nicotine products (cigarettes, vaping, chewing tobacco, nicotine pouches)? ☐ **Yes** ☐ **No**

If yes: ☐ Current user ☐ Former user — quit date: _____

Alcohol

Do you drink alcohol? ☐ **Yes** ☐ **No**

If yes, frequency: ☐ Occasionally ☐ Weekly ☐ Daily

Weight-Loss Medications

Are you currently taking a GLP-1 or similar weight-loss medication (e.g., Ozempic, Wegovy, Mounjaro, Zepbound)? ☐ **Yes** ☐ **No**

If yes, medication & dose: _____ Pounds lost? _____ Over what length of time? _____

Do you use diet pills or other weight-loss supplements? ☐ **Yes** ☐ **No**

Current Medications

Please list ALL prescription and over-the-counter medications you are currently taking:

Medication Name	Dose	Frequency	Prescribing Doctor

Surgical History

Please list your full surgical history to the best of your knowledge:

Procedure	Date of Surgery	Complications (if any)

Patient Name: _____

Women's Health

(If not applicable, please write "N/A" and continue.)

Are you currently pregnant or breastfeeding? ☐ **Yes** ☐ **No**

Date of last menstrual period (if applicable): _____

Any history of breast biopsies, abnormal mammograms, or reproductive health conditions? ☐ **Yes** ☐ **No**

If yes, please describe: _____

Do you currently have breast implants? ☐ **Yes** ☐ **No**

Family History

Any family members with a history of cancer? ☐ **Yes** ☐ **No**

Please list relation to you and type of cancer.

1. _____ Type: _____

2. _____ Type: _____

Any family members with a history of diabetes? ☐ **Yes** ☐ **No**

Please list relation to you and type of diabetes.

1. _____ Type. _____

2. _____ Type: _____

Any family members with a history of heart disease? ☐ **Yes** ☐ **No**

Please list relation to you and cardiovascular condition.

1. _____ Dx: _____

2. _____ Dx: _____

I certify that the information provided above is accurate and complete to the best of my knowledge.

_____

Signature of Patient (or Parent/Guardian) Date

_____

Print Name