Lucie Capek, MD Plastic Surgery

MEDICAL HISTORY **Today's Date__________**

Patient Name____ Age________

Gender M__ F__ Height_____ ft_____inches Weight_________ lbs

1. **ALLERGIES** - *List drug and type of reaction you have i.e. rash, breathing difficulty, etc.*
   ____
   Are you allergic to: LATEX Y__ N__ Adhesive tape Y__ N__ Epinephrine/Adrenaline Y__ N__

2. **MEDS** - *List any prescription or non-prescription **medications** you are currently taking:*
   ____
   ____
   Do you take: Aspirin Y__ N__ NSAIDS Y__ N__ Hormones Y__ N__ Steroids Y__ N__

3. **SUPPLEMENTS** - *List any **vitamins or supplements** you are currently taking:*
   ____
   Do you take: Fish oil Y__ N__ Vit E Y__ N__ Green Tea Y__ N __

4. **MEDICAL HISTORY** – *Check all conditions that you have **currently** or in the **past** and who treats you for them, if applicable:*

- ○ ADHD_____________________________
- ○ Anxiety___________________________
- ○ Arrhythmia________________________
- ○ Arthritis__________________________
- ○ Asthma____________________________
- ○ Bladder problems_________________
- ○ Bleeding disorder_________________
- ○ Blood Clots _______________________
- ○ Breast biopsy_____________________
- ○ Breast Cancer_____________________
- ○ Cold Sores_______________________
- ○ COPD or Emphysema______________
- ○ Dental problems__________________
- ○ Depression_______________________
- ○ Diabetes_________________________
- ○ Dry Eyes_________________________
- ○ Eating Disorder___________________
- ○ GERD/Reflux_____________________
- ○ Heart Attack/ MI__________________
- ○ Heart Disease____________________*
- ○ Heart Murmur____________________*
- ○ Hepatitis _______________________
- ○ High Cholesterol__________________
- ○ HIV_______________________________
- ○ Hypertension______________________
- ○ IBS or IBD_________________________
- ○ Kidney Disease____________________
- ○ Liver Disease______________________
- ○ Nasal Obstruction/Injury_____________
- ○ Neurological problem_______________
- ○ Orthopedic Implant________________*
- ○ Polycystic Ovaries_________________
- ○ Seizures/Stroke/Fainting____________
- ○ Skin Cancer________________________
- ○ Sleep Apnea _______________________
- ○ Thyroid problem___________________
- ○ TMJ problems ______________________
- ○ Varicose Veins_____________________
- ○ Vision Problem_____________________
- ○ Weight loss over 30 lbs_____________
- ○ OTHER: injury or hospitalization

____
____
____
____

* Do you require antibiotic prophylaxis for starred conditions listed Y__ N __

5. **GYN History:** *Complete below, including number of each where applicable.* Last Gyn Exam ______________

Pregnancies ____ Vaginal Deliveries____ C-Sections____ Menopause Y___ N ___

6. **SURGICAL HISTORY**

Check all PROCEDURES you have had, when and by whom:

- Blepharoplasty____________________
- Browlift_________________________
- Rhinoplasty______________________
- Septoplasty______________________
- Chin Implant/Augmentation________
- Jaw or TMJ surgery_______________
- Otoplasty (ear pinning)____________
- Facelift__________________________
- Necklift_________________________
- Thyroid surgery__________________
- Neck liposuction_________________
- Fat grafting/transfer______________
- Chemical Peel___________________
- Laser Rejuvenation_______________
- Laser Hair Removal_______________
- Electrolysis______________________
- Facial Fillers_____________________
- Sculptra__________________________
- Botox____________________________
- Breast Augmentation______________
- Breast Lift________________________
- Breast Reduction__________________
- Mastectomy ______________________
- Lumpectomy______________________
- Breast Reconstruction______________
- Gynecomastia correction (men)______
- Liposuction______________________
  - Standard (mechanical)
  - LASER LipoPlasty
  - Ultrasound-assisted

  ____
  ____
  List areas treated
- Abdominoplasty (tummy tuck)________
- Hernia repair_______________________
- Buttock Lift________________________
- Buttock Augmentation______________
- Thigh Lift – Inner or Outer___________
- Labiaplasty ________________________
- Varicose or spider vein tx.___________
- Other______________________________

  ____
  ____

List any other previous surgical procedures not listed above and dates:

____

____

7. **ANESTHESIA** – *List any problems that YOU or a FAMILY MEMBER have had with anesthesia:*

____

Do you have: dentures Y__ N __ Partial plate Y__ N __ Capped teeth Y__ N __

8. **SOCIAL HISTORY** – *List your DAILY consumption of the following:*

______ Coffee/Tea ______Alcohol ______Cigarettes ______ 'Street' Drugs

9. **FAMILY HISTORY** – *Check all that apply to any FAMILY MEMBER:*

- Skin Cancer___________________
- Heart Disease_________________
- Diabetes_____________________
- Breast Cancer___________________
- Bleeding Disorder________________
- Other__________________________

____

I certify that the above history is true and accurate to the best of my recollection:

Signature____ ***Date***_____________

Relationship to Patient : _____Self _____Parent or Guardian