DELRAY BEACH PLASTIC SURGERY
JOHN G. WESTINE, MD | THE ART & SCIENCE OF BEAUTY

MEDICAL HISTORY

Date:____

Name:____

Age:_______Sex:______ Height: _______________Weight:______________________

1. What is the purpose of this consultation? (*Please specify*)______________________
____

2. Have you ever consulted a plastic surgeon? (*Please give details*)________________
____

3. Have you ever had any plastic surgery? (*Please describe, including dates*)________
____

4. Were you satisfied with the results of any plastic surgery you may have had? ______
____

5. Please list any surgery (ies) you have had:

	TYPE	DATE	SURGEON	SIDE EFFECTS
1.				
2.				
3.				
4.				

6. Please describe reasons for any other hospital admissions: ____________________
____

7. Last general physical exam date: ____
   Medical Doctor: _____________________Phone Number: _____________________

8. Please circle if you have or have had any of the following:

Heart Disease	Stroke	Blood Clots
Lung Disease	Headaches	Stomach Ulcers
Kidney Disease	Glaucoma	Problems with Scars
Liver Disease	Dry Eyes	**Bruise/Bleed easily**
Thyroid Disease	Epilepsy	Cold Sores
Diabetes	Alcoholism	Mitral Valve Prolapse
High Blood Pressure	Anemia	Current Pregnancy
Cancer	Sickle Cell	Tire Easily
Asthma	Recent Infection	Persistent Fever

Please circle if you have or have had any of the following:

Skin Rash	Stress Reduction Therapy	Hemophilia
Recent Visual Change	Shortness of Breath	Tuberculosis
Throat Soreness/Hoarseness	Swelling of Ankles	Emphysema
Parkinson's/Alzheimer	Rheumatic Fever	Arthritis
Facial Pain	Arrythmias	Artificial Joints
Neck Pain	Angina	Hepatitis
Epilepsy	Congestive Heart Failure	Radiation
A-Typical Neuralgias	Heart Attack	Chemotherapy
Fainting/Dizzy Spells	Pacemaker	HIV Positive
Dental Fears	Heart Valve Replacement	AIDS

9. Do you or your family have any other medical condition?
(*Explain)*____
____

10. Have you or any family members had any problems with anesthesia during surgery?
(*Explain*)____
____

11. Have you ever received treatment for a mental condition, emotional problem, or depression? Yes __________NO_____________

12. What medications, herbal supplements, and vitamins do you take or have you taken within the past year? (*Please do not omit anything as medications used during and after surgery may interact adversely).*

Medication Dose Frequency

1.____
2.____
3.____
4.____
5.____

13. Have you ever had a bad reaction or allergic reaction to any of the following? If so, what reaction:

- □ Penicillin____
- □ Other Antibiotics____
- □ Morphine/Codeine____
- □ Sulfa____
- □ Demerol/ Other Narcotics____
- □ Lidocaine/Xylocaine____
- □ Other Anesthetics____
- □ Phenergan____
- □ Other Pain Remedies____
- □ Adhesive,Tape,Latex ____
- □ Iodine____
- □ Hibiclens/Phisohex____
- □ Other Drugs/Medications____
- □ Any Food Allergies____
- □ Any Inhalant Allergies____

12. In the last two weeks have you taken any of the following: (*Please Circle*)

ADVIL	ECHINACEA	NORGESIC
AGGRENOX	ECOTRIN	NUPRIN
ALEVE	EMPRIN COMPOUND	PENTASA
ALKA SELTZER	EXCEDRIN	PEPTO-BISMOL
ANACIN	FISH OIL	PLAVIX
ARTHRITIS PAIN FORMULA	FIORINAL	PRESISTIN
ASCRIPTION	GREEN TEA	ST.JOHN'S WORT
ASPIRIN TABLETS	GINSENG	TRIGESTIC
BAYER	GINKO	VANQUISH
BUFFERIN	GLUCOSAMINE	VICOPROFEN
CAMA ARTHRITIS RELIEVER	GOODIES	VITAMIN C (1000mg daily)
CELEBREX	INDOCIN	VITAMIN E (ok if in multivitamin)
CONDROITIN	MIDOL	WARFARIN
CORICIDIN	MOBIC	4-WAY COLD TABLETS
COUMADIN	MOTRIN	
DOANS PILLS	NAPROSYN	

13. Do you, or have you, used drugs for recreational purposes? The following may interact with some anesthetics:

_____Marijuana _____LSD/Acid
_____Heroin _____Cocaine/Crack
_____Other____

14. Do you smoke? Yes ( ) No ( )
Did you ever smoke? Yes ( ) No ( )
If yes, for how long? _______years ________per day

15. Please describe your alcohol consumption: ____glasses of _______per ________.

My answers to the above questions are true and correct and I believe I understand their significance.

_______________________________________ ____________________
Patient Signature Date

Surgeon's
Notes____
____
____
____
____

Surgeon's Signature____