Base Medical Data

THE CENTER FOR COSMETIC SURGERY & mediSpa
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Name: _____ Nickname _____ Age:_____ Date:_____

Thank you for choosing our office for your consultation! Please check or fill in the following information so I may better help you.

Sex: M F; **Height:** , **Weight** . ***Reason for Visit:***

Your job description:

List ALL your physicians:

Circle, list and explain all that apply:

Social Support: Single, Divorced, Separated, Widowed, Married: live with friend, other:

My **ethnic** background *includes*: Caucasian, N. European, Irish, Mediterranean, Middle Eastern, African-AA, Hispanic, Am-Indian, West-Indies, East-Indian, Asian
Other: Jehovah's Witness

Allergies: None Penicillin Sulfa IV Iodine Latex/Fruit **Other/ Reaction:**

Tobacco / Nicotine (Nicorette, etc): **N**ever. **Y**es, I now smoke_____ packs / day. I stopped smoking _____years ago. **2nd hand? Y N**

FAMILY or PERSONAL History:

YOUR Personal Medical History: Circle and / or explain ALL that apply: NONE

Accutane **N Y**: when_____
AIDS / HIV **N Y**
Flu / Ebola exposure past 21 days **N Y**
Malignant Hyperthermia **N Y**

Anemia (Low blood)
Autoimmune Disease: RA, Scleroderma
Lupus
Asthma / COPD
Bleeding or Clotting Disorders
Hypertension (High Blood Pressure)
Low Blood Pressure **BP: /**

Low Blood Sugar
Diabetes mellitus
GERD / Reflux / Hiatal Hernia
Motion Sickness / Glaucoma
Heart Disease / Heart Failure
Heart Attack / Stroke / bypass / stent
Peripheral Vascular (arterial) Dis
Heart Valve / MVP problems
Hepatitis, Liver Disease
Kidney Failure
Osteo/degenerative Arthritis
Seizure

Skin Cancer
Sun Response: tan, no response, burn
Thyroid Disease
Venous Disease: clots, phlebitis, DVT PE
Behavior Issues: anxiety, depression,
Body dysmorphic synd, dementia,
Gender change, suicidal syndrome
Implant(s) / Prostheses: breast, joints
Body Piercing(s): tongue, nipples, labia
Infections: Yeast, Viral cold sores
Bacterial, MRSA
Snoring, sleep apnea, B/C-PAP

Skin-Cold syndromes: Sickle Cell, Raynauds Synd, AutoImm Dis.

Stem Cell therapy
Other:

Review of Systems:

Pregnancies _____, # Births _____, # Miscarriages _____, # Abortions _____

Anesthesia Concerns: None, Malignant Hyperthermia or List:

Recreational Drugs: **N Y:** (circle): cocaine, crack, meth, heroin, narcotic, marijuana, other:

Alcohol: wine, beer, liquor: _____ ounces / week.

Chronic Narcotics / Sedatives use: eg: codeine, codones, oxycontin, suboxone, methadone, valium, xanax, other:

Are you planning or involved in a law suit regarding any areas of medical concern? N, Y (if yes, explain):

List ALL prior SURGERY, COSMETIC PROCEDURES and INJURIES: NONE

tonsil & adenoids, tubal ligation, appendectomy, lap/open gall bladder, caesarean section, D&C, CABG, stent, Gastric Bypass / Lap Band, neck / back surgery, other:

List ALL MEDICATIONS: NONE

Hormones: HRT, Estrogen, Testosterone Birth Control:
Acne: Spironolactone
Coagulant: Tamoxifen
Erectile Drugs: Viagra; Cialis, Levitra

Cholesterol:
Blood Pressure:
Anti-Coagulants: Coumadin Plavix
Auto-Immune: Humira, Remicade, Rituxan, Herceptin, other:

Heart Meds: Nitroglycerine:

Herbals, Teas or Supplements? Circle or List: NONE

Inhibits:MAOI & SSRI: **St. Johns Wort** {incr photosensitivity & induces cytoP450 which decr Rx activity!}; Yohimbe; Licorice root;
GABA & Serotonin stimulation = Sedation: 5 Hydroxy Tryptophan; **Valerian**; **Kava** {hepatic dysfunction}; Melatonin
Anti-coagulants: Arnica; Bromelain; Black Mushrooms; Clove oil; **Gingko** biloba; **Ginseng** {hypoglycemia}; Ginger; **Garlic** {decr BP}; Bilberry; Dong Quai; Feverfew;
Vitamin E; Honeysuckle; Wintergreen; **Aspirin; Ibuprofen; Naprosyn; Chondroitin/Glucosamine**; **Saw Palmetto; Fish Oil / Essential Fatty Acids; Co-Q-10; Other NSAIDS**:
Stimulants: **Phentermine**; Ma Huang; MetaboLife; MetaBoost; **Ephedra** {halothane potentiates CV effects}; Other Weightloss Supplements:
Liver Dysfunction / Immunosuppression / inhibits cytoP450 which potentiates Rx: **Echinacea**; **Goldenseal**; Milk Thistle;
Other: Aloe {dermatitis, low K}
Multi-Vitamin, Other OTC's:

Any incorrect or missing information may adversely affect my care and my results.
I hereby confirm that all the information provided is complete and accurate to the best of my knowledge.

☐ ***I hereby confirm that there has been "NO CHANGE" in my medical condition since last documented in this record.***

Signed: Date: