

**Sinno Center for Plastic Surgery**

**MEDICAL INFORMATION FORM**

For your information, it is necessary that you answer these questions as accurately as possible so that we can determine your physical condition before undergoing surgery.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

1. DO YOU HAVE:	Yes	No	4. DO YOU TAKE:	Yes	No
Heart disease	_____	_____	Blood thinners	_____	_____
High blood pressure	_____	_____	Heart Medication	_____	_____
Diabetes	_____	_____	High blood pressure medicine	_____	_____
Epilepsy	_____	_____	Diuretics (water pills)	_____	_____
Thyroid disease	_____	_____	Aspirin	_____	_____
Asthma	_____	_____	Frequency	_____	

2. HAVE YOU EVER HAD:	Yes	No	5. DO YOU TAKE, OR HAVE YOU EVER TAKEN	Yes	No
Rheumatic fever	_____	_____	Steroids (cortisone)	_____	_____

3. DO YOU HAVE:	Yes	No	6. LIST MEDICINE ALLERGIES:	
Shortness of breath	_____	_____	_____	
Dizzy spells	_____	_____	_____	
Swelling of ankles	_____	_____	_____	
Chest pain	_____	_____		
Prolonged bleeding	_____	_____		
Jaundice	_____	_____		

7. DO YOU SMOKE OR USE NICOTINE PRODUCTS:	Yes	No
	_____	_____

8. Name of Primary Care Physician/Phone: \_\_\_\_\_

9. List operations you have had: \_\_\_\_\_

\_\_\_\_\_

10. List medications you take: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. Please list any unusual medical problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_