National Center for Plastic Surgery
7601 Lewinsville Rd Suite 400
McLean, VA 22102
(703) 287-8277

# Health Information Form

Health Information as of _____(enter today's date)
(Please Print Legibly & Answer All Questions to the Best of Your Knowledge)

*Confidential Record: Information contained here will not be released unless you have authorized us to do so.*

| Name: | Reason for Visit: | Age: |
|---|---|---|
| Height: | Weight: | Current Physician(s): |
| List all Surgeries (Hospitalization and the Date of Occurrence: | | |
| List any Serious Illnesses and/or Accidents: | | |
| List ALL Drug and/or Latex Allergies: | | |
| List all medications (incl. name of drug, dosage, and frequency) you are presently taking or have taken within the last month: | | |

Do you have or have you had any of the following: (circle for each, give date occurred if 'Yes')

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Aids / HIV | No | Yes | Epilepsy / Seizures | No | Yes | Kidney Problems | No | Yes |
| Arthritis | No | Yes | Facial Pain | No | Yes | Pneumonia | No | Yes |
| Asthma | No | Yes | Fever Blisters | No | Yes | Sinus Issues / Infections | No | Yes |
| Bronchitis | No | Yes | Goiter / Thyroid | No | Yes | Stroke | No | Yes |
| Cancer | No | Yes | Hay Fever / Allergies | No | Yes | Tonsillitis | No | Yes |
| Depression | No | Yes | Headaches / Migraine | No | Yes | Tuberculosis | No | Yes |
| Diabetics | No | Yes | Heart Trouble | No | Yes | Ulcers | No | Yes |
| Dizziness / Vertigo | No | Yes | Hepatitis | No | Yes | | | |
| Ear Infection | No | Yes | High Blood Pressure | No | Yes | | | |

| | | | | | |
|---|---|---|---|---|---|
| Do you smoke? | No | Yes | If yes, how much? | _____ Pack(s)/Day | How long? ____ Year(s) |
| Do you drink alcohol? | No | Yes | If yes, how much? | _____ | How often? ____ |
| Do you have bleeding or bruising problems? | No | Yes | If yes, describe? | _____ | |
| Do you have problems with scarring? | No | Yes | If yes, describe? | _____ | |
| Do you have any history of problems with anesthesia? | No | Yes | If yes, describe? | _____ | |

The above information is accurate and complete to the best of my knowledge.

Signature _____ Date _____