Evangelisti

RECONSTRUCTIVE & AESTHETIC SURGERY

Patient's Name: _____ **Date:** _____

Date of Birth: _____ **Height:** _____ **Weight:** _____

Are you allergic to, or have you ever had a problem with a prescription, or over the counter medication or drug?

Drug 1: _____ Reaction: _____
Drug 2: _____ Reaction: _____
Drug 3: _____ Reaction: _____

List all medications, prescriptions or over-the counter, that you now take on a regular basis (Include Aspirin, Aleve, and Sinus medication):

_____
_____
_____
_____
_____

List all previous surgeries and approximate dates:

_____
_____
_____
_____
_____

Have you or a blood relative ever had a problem or reaction to anesthesia?..... no ___ yes ___

Do you smoke?..... no ___ yes ___
Number of Packs/Day?_____ Number of Years?_____
Have you ever smoked?..... no ___ yes ___

Do you drink alcohol?..... no ___ yes ___
If yes, how many drinks per day?_____
If yes, how many drinks per week?_____

Do you now use, or have you ever used any recreational (street) drugs?..... no ___ yes ___

Do you have cancer?..... no ___ yes ___

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Do you have:
Hepatitis?..... no ___ yes ___
HIV?..... no ___ yes ___
Tuberculosis?..... no ___ yes ___
Herpes?..... no ___ yes ___
Other infections?.....no ___ yes ___

Have you ever had:
Asthma?..... no ___ yes ___
Emphysema or lung
Problems?.....no ___ yes ___
Chronic bronchitis?.....no ___ yes ___
Recent cold or flu?.....no ___ yes ___

Have you ever had:
Mitral Valve Prolapse?.....no ___ yes ___
Heart attack?..... no ___ yes ___
Angina or chest pain?..... no ___ yes ___
Heart failure?..... no ___ yes ___
High blood pressure.....no ___ yes ___
High cholesterol?..... no ___ yes ___
Peripheral vascular
Disease?..... no ___ yes ___

Have you ever had:
Diabetes?.....no ___ yes ___
Thyroid problems?.....no ___ yes ___

Have you ever had:
Arthritis.....no ___ yes ___
What joints?: _____

Have you ever had:
A seizure?.....no ___ yes ___
A stroke?..... no ___ yes ___
Fainting or loss of
Consciousness?..... no ___ yes ___
Mental Illness…….....no ___ yes ___

Have you ever had:
Ulcer disease?.....no ___ yes ___
Hiatus Hernia.....no ___ yes ___

Have you ever had:
Anemia or low blood count?..... no ___ yes ___
Excessive bleeding, bruising
in yourself or in your family?.....no ___ yes ___
Sickle cell disease trait?..... no ___ yes ___

Have you ever had:
Kidney or urinary problems..... no ___ yes ___
Date of last rectal exam: _____

Do you have:
Caps, crowns, bridges or
dentures?.....no ___ yes ___
Arthritis or neck or jaw?.....no ___ yes ___
Loose or cracked teeth?.....no ___ yes ___
Do your have TMJ?.....no ___ yes ___

Female:
Is there any possibility
you are pregnant?.....no ___ yes ___
Date of last period: _____
Date of last breast exam: _____

Do you have any concerns or medical problems that were not covered in this questionnaire?

If yes, please explain: _____
_____
_____
_____

SIGNATURE _____
DATE _____

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