Associated Plastic Surgeons & Consultants, P.C.
Cosmetic & Reconstructive Plastic Surgery
Diplomate American Board of Plastic Surgery
www.associatedplasticsurgeons.com
864 West Jericho Turnpike
West Hills, New York 11743
631-423-1000

Patient Name: ______________________ **Date of Birth:** ______________

Date: ______________

Are you currently under the care of, or have you ever been treated by a medical physician for any significant illness other than colds, flu or virus? No ☐

Yes ☐ (Please Complete) ______________________

____

____

Have you ever had any surgical procedures in the past?

Date	Type of Surgery	Doctor's Name	Hospital

Do you have any allergies to medications?

	No	**Yes**
• Penicillin	☐	☐
• Local Anesthesia	☐	☐

• Other (please specify) ______________________

____

Are you presently taking any medications?

	No	**Yes**
• Aspirin	☐	☐
• Oral Contraceptives	☐	☐
• Blood Thinners	☐	☐

• Other (please specify) ______________________

____

Do you have history of

•Bleeding tendencies? ☐ No ☐ Yes
•History of diabetes? ☐ No ☐ Yes
•History of hepatitis? ☐ No ☐ Yes

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Patient Name: ______________________ **Date of Birth:** ______________

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Are you currently under the care of, or have you ever been treated by a medical physician for any significant illness other than colds, flu or virus? No ☐
Yes ☐ (Please Complete)

____

Have you ever had any surgical procedures? (please use the back to continue as necessary)

Date	Type of Surgery	Doctor's Name	Hospital

Do you have any allergies to medications?

Date								
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Penicillin	☐	☐	☐	☐	☐	☐	☐	☐
Local Anesthesia	☐	☐	☐	☐	☐	☐	☐	☐
Other								

Are you presently taking any medications? (Check if indicated)

Date								
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Aspirin	☐	☐	☐	☐	☐	☐	☐	☐
Oral Contraceptives	☐	☐	☐	☐	☐	☐	☐	☐
Blood Thinners								
Other								

Please include below any Vitamins, "Herbal" or "Over-the-counter" medications as some of these may sensitize you to anesthesia or promote bleeding.

Do you have history of
Bleeding tendencies? ☐ Yes ☐ No
Diabetes? ☐ Yes ☐ No
Hepatitis? ☐ Yes ☐ No

Do you smoke cigarettes ☐ **Yes** ☐ **No** **Packs/Day** ______
Do you use alcohol in other than a social situation? ☐ **Yes** ☐ **No**
If yes, how frequently? _________
Would you like to bring anything else to the doctor's attention? No ☐ **Yes** ☐ ***(please specify)***

____

If any history of use of controlled substances, please bring to your doctor's attention

Patient's or Guardian's Signature: ______________________________