

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

## ROMANELLI COSMETIC SURGERY MEDICAL HISTORY

Please describe the purpose of today's consultation:

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**Circle One**

Yes No Are you allergic to any medications? List: \_\_\_\_\_  
Specify reaction: \_\_\_\_\_

Yes No Are you allergic to latex? \_\_\_\_\_ Specify reaction: \_\_\_\_\_

Yes No Have you taken prednisone, cortisone or ACTH in the last year?

Yes No Have you taken Accutane in the last year?

Yes No Are you taking any drugs or medications?

Please list, with dosages, ALL medications, including birth control pills, aspirin, any over the counter medications, vitamins or any dietary supplements:

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**Gynecological History**

# Children \_\_\_\_\_; # Vaginal Births \_\_\_\_\_; # C Sections \_\_\_\_\_; Date of LMP \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Please *Circle* any of the following problems which you have *now or have had in the past*:

- |                            |                     |                          |
|----------------------------|---------------------|--------------------------|
| Heart disease              | Emphysema           | Bell's Palsy             |
| Heart attack               | Chronic cough       | Radiation Therapy        |
| Heart murmur               | Tuberculosis        | Chemotherapy             |
| Rheumatic fever            | Asthma              | Seizure disorder         |
| Bypass surgery             | Loss of Vision      | Fainting or dizzy spells |
| Heart surgery              | Chronic bronchitis  | Artificial joints        |
| Artificial heart valve     | Pneumonia           | Orthopedic hardware      |
| Pacemaker or Defibrillator | Sinus problems      | Blood Diseases           |
| Angina (chest pain)        | Kidney problems     | Anemia                   |
| High blood pressure        | Stomach ulcers      | Easy bruising            |
| Stroke                     | Diabetes            | Excessive bleeding       |
| Cancer                     | Thyroid Disease     | Psychiatric treatment    |
| Glaucoma                   | Hepatitis A, B or C | Blood Transfusions       |
| Arthritis                  | Liver Disease       | Other                    |
| Neck problems              | Jaundice            | _____                    |
| Facial nerve paralysis     |                     |                          |

(please turn over)

Please list ALL previous surgeries, including Plastic Surgeries:

Year	Surgery

**Surgical Experience**

Yes No Have you had any problems healing?  
 Yes No Have you ever had keloids (very thick scars)?

**Anesthesia Experience**

Yes No Have you ever had general anesthesia?  
 Yes No Have you ever had any problems with anesthesia?  
 Yes No Have any family members have any problems with anesthesia?

**Personal Habits**

Yes No Do you smoke? If so, how much: \_\_\_\_\_  
 Yes No Did you previously smoke? If so, how much \_\_\_\_\_  
 How much alcohol do you consume: \_\_\_\_\_  
 Any other drugs, legal or not (please specify) \_\_\_\_\_

**Please list all physicians you have seen in the last 2 years:**

Name \_\_\_\_\_ Telephone \_\_\_\_\_  
 Address \_\_\_\_\_  
 Reasons for seeing this physician: \_\_\_\_\_

Name \_\_\_\_\_ Telephone \_\_\_\_\_  
 Address \_\_\_\_\_  
 Reasons for seeing this physician: \_\_\_\_\_

Name \_\_\_\_\_ Telephone \_\_\_\_\_  
 Address \_\_\_\_\_  
 Reasons for seeing this physician: \_\_\_\_\_

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

Signature \_\_\_\_\_