Longwood Plastic Surgery, P.C.

(617) 383-6250/(617) 383-6255 (Fax)

Patient Name: _____

Phone Number: (____)_____ Cell Phone No.: (_____)_____

DOB: _____Age: _____Male/Female_____Height:_____Weight_____

To whom may we speak regarding your care (family member/friend)?
Name_____Relationship_____ Phone # (_____)_____
Name_____Relationship_____ Phone # (_____)_____

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All Physicians Involved in Your Care:

Name	Specialty
_____	_____
_____	_____
_____	_____

Reason for today's visit: _____
_____

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Current Medications Prescription & Non-Prescription:

Name of Drug	Dosage
_____	_____
_____	_____
_____	_____

Any Allergies and/or Sensitive to Medications:
_____

Previous Surgeries:

Procedure/Surgery	Approximate Date
_____	_____
_____	_____
_____	_____

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Personal History:	Yes	No		Yes	No
1. Heart Problems	_____	_____	11. Kidney Problems	_____	_____
2. Liver Problems	_____	_____	12. Ulcers	_____	_____
3. Psychiatric Problems	_____	_____	13. Diabetes	_____	_____
4. High Blood Pressure	_____	_____	14. Cancer	_____	_____
5. Arthritis	_____	_____	15. Pregnant	_____	_____
6. HIV+/or AIDS	_____	_____	16. History Bleeding Problems	_____	_____
7. Do you drink alcohol?	_____	_____	17. Family History Bleeding Problems	_____	_____
If yes, how much?	_____		18. Problems with Anesthesia?	_____	_____
8. Do you smoke?	_____	_____	19. Family History of Problems with Anesthesia?	_____	_____
If yes, how much?	_____		20. Sleep Apnea	_____	_____
9. Did you smoke in the past?	_____	_____	21. Asthma	_____	_____
Year you quit_____					
10. Is second-hand smoke in your home or office?	_____	_____			

If you answered yes to any of the above questions, please explain:_____
_____
_____