SCOTTSDALE CENTER FOR PLASTIC SURGERY

(480) 423-1973

Health Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
First Middle Last

Age _____ Birthdate _____ Height _____ Weight _____ Gender ❒ Female ❒ Male

Purpose of Visit: _____

_____

Previous Surgeries with Dates: (Including cosmetic)

_____

_____

_____

Health Problems Past & Present: (mark all that apply)

❒ Diabetes ❒ High Blood Pressure ❒ Heart Problems

❒ Easy Bruising ❒ Lung/Breathing Problems ❒ Bleeding/Clotting Problems

❒ Cancer ❒ Psychiatric / Depression

❒ Other: _____

Please explain all positive responses: _____

_____

Do you smoke? ❒ No ❒ Yes, How many packs a day? _____

Medications: (include all Prescriptive, Over-The-Counter, Vitamins and Herbal medications taken regularly)

_____

_____

_____

Drug or Latex Allergies: (please indicate if none)

_____

_____

Primary Physician _____ Phone _____
First and Last Name

Date of Last Physical: _____

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

Signature _____ **Date** _____