reveèrt
Plastic Surgery Center Mexico

Personal Medical History

Actually Date:

Name: _____

Birthdate:_____Age: _____

Height: Weight:

Blood Group:

Physician:_____

Telephone numbers:_____
_____

Your current medical
condition:_____

Do you smoke? ☐ yes ☐ no

If yes, for how long?_____ How many cigarettes per day?_____

If you have recently quit smoking, how long have you not smoked?_____

List prescription and non-prescription medications you are
taking:_____
_____
_____
_____

Drug sensitivity and allergies
(describe):_____
_____
_____

Name of health insurance carrier:_____

Have you ever been told you had one of the following?

Lung disorder ☐ yes ☐ no

High blood pressure ☐ yes ☐ no

Heart trouble ☐ yes ☐ no

Nervous disorder ☐ yes ☐ no

Disease or disorder of the digestive tract ☐ yes ☐ no
Any form of cancer ☐ yes ☐ no
Disease of the kidney ☐ yes ☐ no
Diabetes ☐ yes ☐ no

Arthritis ☐ yes ☐ no

Hepatitis ☐ yes ☐ no

Disease or disorder of the blood? (describe)_____

Any physical defect or deformity? (describe)_____

Any vision or hearing disorders? (describe)_____

Any life-threatening conditions? (describe)_____

Any contagious disorders? (describe)_____
(see next page)

Have you been treated by a physician or been disabled or hospitalized during the last year? (describe)
_____
_____

Have you had or been advised to have a surgical operation within the last five years? (describe)
_____
_____

Date of last
physical:_____
_____

Family history — list important medical problems of your
parents:_____
Mother:_____
_____
Father:_____
_____

Any other special medical information:_____
_____
_____
_____
_____
_____

Physical exploration

Program surgery

Notes after surgery