R OF THE AMERICAN SOCIETY OF PLASTIC SURGEONS	Cosmetic and Recons	tructive Plastic Surg TFIED, AMERICAN B	MAN, M.D., P.A. ery • Breast and Body Contourin OARD OF PLASTIC SURGERY History	ng Member of the American Society for Aesthetic Plastic Surgery
Date:	Name of person	completing form	(if different from patient)	
1. Name:			Age:	Sex: M / F
2. Occupation	1:	14 A 1	Height:	Weight:
3. Reason for	today's visit:		<u>}</u>	
4. Who is you	r regular physician?			
Physician's	address and phone r	umber:		
5. Whom may	we thank for referri	ng you to our offi	ce?	
Doctor	(name)	1110	Family Member	
Friend	(name)		Other (please list)	
Google	e / Internet (Please ci	rcle &/or name of	site)	
6. How is you	r general health?	Excellent	Good Fair	Poor
			O Disconsiste Verse No.	

7. Have YOU ever had any of the following illnesses? Please circle Yes or No. If yes, please state the date. Please check $\sqrt{}$ if an immediate family member has had one of these illnesses.

	Y	OU	$\underline{Date} \qquad \qquad \sqrt{\underline{Family Member}}$
Diabetes	Yes	No	
High blood pressure	Yes	No	
Chest pain	Yes	No	
Heart disease	Yes	No	
Sleep apnea	Yes	No	
Shortness of breath	Yes	No	
Asthma	Yes	No	
Stroke	Yes	No	
Cancer	Yes	No	
Seizures, epilepsy	Yes	No	
Hepatitis, jaundice	Yes	No	
Arthritis	Yes	No	
Stomach ulcer	Yes	No	
Anemia	Yes	No	
Bleeding disorder	Yes	No	
Depression	Yes	No	
Nervous breakdown	Yes	No	
Thyroid disorder	Yes	No	
Glaucoma	Yes	No	
Kidney disease	Yes	No	
ease list any other medic	al prob	lame	

8. Please list any other medical problems:

Мемв

CONTINUED ON OTHER SIDE

Ronald M. Friedman, M.D., P.A. Health History

What is your reaction?	Please list any drug allergies: What is your reaction? Are you allergie to (please circle if applicable): adhesives, tape, bandaids, latex, gloves, Dermabor 2. Do you smoke or use any of these products? Yes / No (Please circle if applicable): Cigarettes, marijuana, other recreational drugs If yes, how many times per day? How many years? If no, have you ever been a smoker? Yes No Occasionally Weekly Daily 4. Do you exercise? No Occasionally Weekly Daily 5. Do you take aspirin / ibuprofen regularly? Yes No 6. Do you bleed excessively? Yes No 7. Do you form unsightly scars? Yes 8. Are you under any excessive emotional distress? Yes / No 8. Are you had any recent weight changes? Yes 9. Have you had any recent weight changes? Yes 16. In the past year, have you had any of the following? Complete physical exam Yes No Blood tests Yes No	0. Please list all current medication	ns (includin	g dosages	5):			
Are you allergic to (please circle if applicable): adhesives, tape, bandaids, latex, gloves, Dermab 12. Do you smoke or use any of these products? Yes / No (Please circle if applicable): Cigarettes, cigars, nicorette gum, nicotine patches, electronic cigarett vapor cigarettes, marijuana, other recreational drugs If yes, how many times per day? How many years? If no, have you ever been a smoker? Yes No When did you quit?	What is your reaction?	Medication	Dosage			Reason for taking		
What is your reaction?	What is your reaction?							
What is your reaction?	What is your reaction?							
What is your reaction?	What is your reaction?		_	2				
Are you allergic to (please circle if applicable): adhesives, tape, bandaids, latex, gloves, Dermab 2. Do you smoke or use any of these products? Yes / No (Please circle if applicable): Cigarettes, cigars, nicorette gum, nicotine patches, electronic cigarette vapor cigarettes, marijuana, other recreational drugs If yes, how many times per day? How many years? If no, have you ever been a smoker? Yes No When did you quit?	Are you allergic to (please circle if applicable): adhesives, tape, bandaids, latex, gloves, Dermabole 2. Do you smoke or use any of these products? Yes / No (Please circle if applicable): Cigarettes, cigars, nicorette gum, nicotine patches, electronic cigarettes vapor cigarettes, marijuana, other recreational drugs If yes, how many times per day? How many years? If no, have you ever been a smoker? Yes No When did you quit? 3. Do you drink alcohol? No Occasionally WeeklyDaily 4. Do you exercise? No Occasionally WeeklyDaily 5. Do you take aspirin / ibuprofen regularly? Yes No 6. Do you form unsightly scars? Yes / No 7. Do you form unsightly scars? Yes / No 8. Are you under any excessive emotional distress? Yes / No If yes, please explain: 9. Have you had any recent weight changes? Yes No If yes, please explain:	1. Please list any drug allergies :						
 2. Do you smoke or use any of these products? Yes / No (Please circle if applicable): Cigarettes, cigars, nicorette gum, nicotine patches, electronic cigarette vapor cigarettes, marijuana, other recreational drugs If yes, how many times per day? How many years? If no, have you ever been a smoker? Yes No When did you quit? (If no, have you ever been a smoker? Yes No When did you quit? (If no, have you ever been a smoker? Yes No When did you quit? (If no, have you ever been a smoker? Yes No When did you quit? (If no, have you ever been a smoker? Yes No When did you quit? (If no, have you ever been a smoker? Yes No (If no, have you ever been a smoker? Yes No (If no, have you ever been a smoker? Yes No (If no, have you ever been a smoker? Yes No	 2. Do you smoke or use any of these products? Yes / No (Please circle if applicable): <u>Cigarettes, cigars, nicorette gum, nicotine patches, electronic cigarettes</u> <u>vapor cigarettes, marijuana, other recreational drugs</u> If yes, how many times per day? How many years? If no, have you ever been a smoker? Yes No When did you quit? 3. Do you drink alcohol?NoOccasionallyWeeklyDaily 4. Do you exercise?NoOccasionallyWeeklyDaily 5. Do you take aspirin / ibuprofen regularly? Yes No 6. Do you bleed excessively? Yes No 7. Do you form unsightly scars? Yes No 8. Are you under any excessive emotional distress? Yes / No If yes, please explain: 9. Have you had any recent weight changes? Yes No If yes, please explain: 0. In the past year, have you had any of the following? Complete physical exam Yes No Blood tests Yes No Chest x-ray Yes No EKG Yes No 	What is your reaction?		_				
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vapor cigarettes, marijuana, other recreational drugs If yes, how many times per day? How many years? If no, have you ever been a smoker? Yes No When did you quit?	vapor cigarettes, marijuana, other recreational drugs If yes, how many times per day? How many years? If no, have you ever been a smoker? Yes No When did you quit?	2. Do you smoke or use any of the	se products	? Yes/N	No			
If yes, how many times per day? How many years? If no, have you ever been a smoker? Yes No When did you quit? 3. Do you drink alcohol? No Occasionally Weekly Daily 4. Do you exercise? No Occasionally Weekly Daily 5. Do you take aspirin / ibuprofen regularly? Yes No 0 0 6. Do you bleed excessively? Yes No 0 0 0 7. Do you form unsightly scars? Yes No 0	If yes, how many times per day? How many years? If no, have you ever been a smoker? Yes No When did you quit? 3. Do you drink alcohol? No Occasionally Weekly Daily 4. Do you exercise? No Occasionally Weekly Daily 5. Do you take aspirin / ibuprofen regularly? Yes No Occasionally Weekly Daily 5. Do you take aspirin / ibuprofen regularly? Yes No Occasionally Weekly Daily 6. Do you bleed excessively? Yes No No Occasionally Weekly Daily 7. Do you form unsightly scars? Yes No No If yes, please explain:	(Please circle if applicable): Ci	garettes, cig	gars, nico	rette gum	, nicotine patches, o	electronic cigarette	
If no, have you ever been a smoker? Yes No When did you quit? 3. Do you drink alcohol? No Occasionally Daily 4. Do you exercise? No Occasionally Daily 5. Do you take aspirin / ibuprofen regularly? Yes No	If no, have you ever been a smoker? Yes No When did you quit? 3. Do you drink alcohol? No Occasionally Daily 4. Do you exercise? No Occasionally Daily 5. Do you take aspirin / ibuprofen regularly? Yes No Occasionally Daily 5. Do you take aspirin / ibuprofen regularly? Yes No Occasionally Daily 6. Do you bleed excessively? Yes No	vapor cigarettes, marijuana,	other recrea	ational dr	ugs			
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Mammogram Ves No	EKG Yes No	-						
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Thank you for taking the time to complete this form thoroughly. Your accurate responses will help us to better serve your health care needs.