RONALD M. FRIEDMAN, M.D., P.A.

Cosmetic and Reconstructive Plastic Surgery • Breast and Body Contouring

BOARD CERTIFIED, AMERICAN BOARD OF PLASTIC SURGERY

MEMBER OF THE AMERICAN SOCIETY OF PLASTIC SURGEONS

MEMBER OF THE AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY

Health History

Date: _____ Name of person completing form (if different from patient) _____

1. Name: _____ Age: _____ Sex: M / F
2. Occupation: _____ Height: _____ Weight: _____
3. Reason for today's visit: _____
4. Who is your regular physician? _____

   Physician's address and phone number: _____
5. Whom may we thank for referring you to our office?

   Doctor (name) _____ Family Member _____

   Friend (name) _____ Other (please list) _____

   Google / Internet (Please circle &/or name of site) _____
6. How is your general health? ____ Excellent _____ Good _____ Fair _____ Poor
7. Have **YOU** ever had any of the following illnesses? Please circle Yes or No. If yes, please state the date. Please check √ if an immediate family member has had one of these illnesses.

	YOU		Date	√ 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	_____	_____

8. Please list any other medical problems: _____

_____

CONTINUED ON OTHER SIDE

1/15

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

Health History

9. Please list all prior surgeries and dates:_____

_____

10. Please list all current medications (including dosages):

Medication	Dosage	Reason for taking

11. Please list any **drug allergies**: _____

What is your reaction? _____

Are you **allergic** to (please circle if applicable): adhesives, tape, bandaids, latex, gloves, Dermabond

12. 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? _____

13. Do you drink alcohol? _____No _____ Occasionally _____Weekly _____Daily

14. Do you exercise? _____No _____ Occasionally _____Weekly _____Daily

15. Do you take aspirin / ibuprofen regularly? Yes No

16. Do you bleed excessively? Yes No

17. Do you form unsightly scars? Yes No

18. Are you under any excessive emotional distress? Yes / No If yes, please explain: _____

19. Have you had any recent weight changes? Yes No

If yes, please explain: _____

20. 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
Mammogram	Yes	No
EKG	Yes	No

21. What are your hobbies? _____

Thank you for taking the time to complete this form thoroughly. Your accurate responses will help us to better serve your health care needs.

11/15