ARKOULAKIS PLASTIC SURGERY
PATIENT HISTORY

Name: _____ Age: _____ Sex: ☐M ☐F

Reason for Visit: _____ Ht: _____ Wt: _____

Daily Medications *(Name & dosage; please include vitamins and nutritional supplements):*

_____

_____

Drug Allergies *(Name & type of reaction):* _____

_____

Previous Surgery *(Type & date):* _____

_____

PAST MEDICAL HISTORY:	Yourself	Family Members	Relationship
Heart Disease (heart attack)			
Heart Failure			
Abnormal Rhythm			
High Blood Pressure			
Mitral Valve Prolapse			
Diabetes			
Kidney Disease			
Asthma			
Hepatitis			
Jaundice			
Seizures			
Bleeding Tendency			
Adverse Reaction to Anesthesia			

Please list any other illness that required surgery, hospitalization or chronic treatment _____

_____

Do you smoke? ☐No ☐Yes If yes, number of cigarettes per day _____ for _____ years
Do you drink alcoholic beverages? ☐No ☐Yes If yes, how much? _____

FOR WOMEN ONLY:

Last Mammogram	Date	Result	
Previous Breast Biopsy	Date	Result	
Breast Cancer History	Personal	Family	Relationship
If considering breast surgery	Bra size	Desired size	
Date of Last Menstrual Period			

Have you ever used Accutane? ☐No ☐Yes If yes, when did you last take it? _____
Are you currently on some type of daily skin care regimen? ☐No ☐Yes

If so, please describe: _____

_____ _____

Signature of person completing form Date