Itzhak Nir MD, FACS
palms wellington
PLASTIC SURGERY
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Patient Medical History Questionnaire

Date:_____
Patient Name:_____
Age:_____ Sex:_____
Reason for today's visit:_____
Are you allergic to any medications? _____Yes _____No
If YES please list:_____

Please List Any Past Medical History: (□ None)
□ Hypertension □ Diabetes □ Heart Disease □ Heart Attack
□ Stroke □Asthma □ Emphysema □Tuberculosis
□ Liver Disease/Hepatitis □ Kidney Disease □ Peptic Ulcer Dis.
□ Vascular Disease □ Bleeding Problems □ Thyroid Disease
□ Prostate Disease □ Gynecologic Disease:_____
□ Skin Cancer History □ Other Cancer Hx: _____
□ Other Medical Conditions: _____

Please List Any Past Surgery (Including Cosmetic Surgery):

_____

_____

_____

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):
1._____ 4._____
2._____ 5._____
3._____ 6._____

Do You: □Smoke(Amount_____) □Drink(Amount_____)
□Use recreational drugs(past or present): Type_____
□Have you ever received a blood transfusion: When?_____

I certify that to the best of my knowledge all of the information provided to Dr. Nir on this questionnaire is true and correct. I take full responsibility for any complications that may arise from either purposeful or accidental omission of information.

Patient Signature:_____ **Date:** _____