alvarez
PLASTIC SURGERY

Patient Information

Patient Name_____ Date_____

Address_____ Suite/Apt_____

City_____ State_____ Zip_____

Home ( ) _____-_____ Cell ( ) _____-_____

Work ( ) _____-_____ E-Mail_____

D.O.B._____/_____/_____ Age_____ Sex_____ Marital Status_____

Best Contact Method ( ) Cell ( ) Home ( ) Work ( ) Email ( ) Mail

In case of emergency, notify_____

Phone ( ) _____-_____ Relationship_____

Patient Employer_____ Occupation_____

Employer Address_____ Suite_____

City_____ State_____ Zip_____

Spouse's Name _____ Employer_____

How were you referred to our office?

( ) Internet ( ) Patient ( ) Word of Mouth ( ) Realself ( ) Friend
( ) Other_____ ( ) Doctor_____

Alvarez Plastic Surgery
605 Lincoln Rd. Suite 430A
Miami Beach, FL 33139
P: 305.600.4146 F: 305.397.8596

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Medical History

Name of Primary Physician_____Phone ( ) _____-_____

Address_____Suite_____

City_____State_____Zip_____

Office ( ) _____-_____ Fax ( ) _____-_____

Date of last exam_____Height_____Weight_____

Past Medical History

Do you have a history of any of the following:

___ Heart Disease
___ Diabetes
___ Asthma
___ Hepatitis
___ Hypo/Hyper Thyroid
___ Rheumatic Fever
___ Joint Replacement or Implant
___ Myasthenia Gravis
___ Heart Murmur
___ Hypertension
___ Seizures
___ Cancer
___ Malignant Hyperthermia
___ Sexually Transmitted Disease
___ HIV/AIDS
___ Stomach Problems/Ulcers
___ Cold Sore/Fever Blister
___ Other, Specify_____

Have you ever taken Fen-Phen? ☐ YES ☐ NO

If Yes, when?_____

Have you ever taken Accutane? ☐ YES ☐ NO

If Yes, when?_____

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List any previous Surgery or Hospitalizations with approximate dates:_____

_____

_____

_____

_____

_____

_____

Current medications: Please list all medications you are taking, prescribed or over-the- counter

_____

_____

_____

_____

_____

_____

Do you have any drug allergies? ☐ YES ☐ NO

If YES, please list name of the drug(s) you are allergic to: _____

_____

_____

Are you allergic to LATEX? ☐ YES ☐ NO

If YES, what type of reaction occurs?_____

_____

Smoking History:

Do you smoke? ☐ YES ☐ NO

If YES, How much?_____

If you smoked previously, when did you quit?_____

Do you drink alcohol? ☐ YES ☐ NO

( ) Daily ( ) Weekly ( ) Weekends ( ) Occasionally

Do you use any controlled substances? ☐ YES ☐ NO

If YES, which controlled substances_____

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Please indicate if you are experiencing any of the following symptoms:

___ Hearing Difficulty

___ Blurred Vision

___ Nosebleeds

___ Abnormal Bleeding

___ Vomiting

___ Joint pain/Stiffness

___ Painful Urination

___ Dysphagia (Difficulty breathing)

___ Chronic cough

___ Shortness of breath

___ Chest pain

___ Nausea

___ Swelling

___ Blood in Stool/Urine

___ Syncope (fainting)

Woman Only

Are you pregnant	☐ YES	☐ NO
Are you Nursing	☐ YES	☐ NO
Are you taking birth control pills	☐ YES	☐ NO
Do you have a menstrual problems	☐ YES	☐ NO

Date of last menstrual period: _____/_____/_____

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my physician, or any member of the staff responsible for any errors or omission that I may have made in the completion of this form.

Patient Signature_____**Date**_____/_____/_____

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