WestlakePlasticSurgery™
DR. ROBERT CARIDI

Medical History Form

Name: _____

Age: _____ **Height:** _____ **Weight:** _____

MEDICAL HISTORY: Please check the appropriate answer if you have or have ever had:

Abnormal bleeding	☐ Yes ☐ No	Shortness of breath/lung problem	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Fainting or black-out spells	☐ Yes ☐ No
Stomach ulcer/reflux	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Excessive scarring/keloids	☐ Yes ☐ No
Heart murmur	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No
Irregular/rapid heartbeat	☐ Yes ☐ No	Autoimmune disorder	☐ Yes ☐ No
AIDS, ARC or HIV positive	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Stroke or brain attack	☐ Yes ☐ No	Arthritis/joint pain	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Disorder of the eyes	☐ Yes ☐ No	Blood clots	☐ Yes ☐ No
Hernia	☐ Yes ☐ No	Birth control use	☐ Yes ☐ No

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE:_____

Do you smoke? ☐ Yes ☐ No How much? _____
Consume alcohol? ☐ Yes ☐ No How much? _____
Use recreational drugs? ☐ Yes ☐ No What kind? _____
Use diet medications? ☐ Yes ☐ No Type? _____
Use herbal products? ☐ Yes ☐ No List: _____
Take vitamins? ☐ Yes ☐ No Kind? _____
Take Aspirin? ☐ Yes ☐ No Dose? _____
How many children do you have? _____

LIST ALL MEDICATIONS YOU TAKE (ALL prescribed and over the counter medications, including pain and homeopathic/herbal medications):

_____

_____

ALLERGIES: **Medication**: ☐ Yes ☐ No **Latex**: ☐ Yes ☐ No **Seasonal**: ☐ Yes ☐ No **Food**: ☐ Yes ☐ No
Details: _____

_____

LIST ALL SURGERIES (Please include ALL cosmetic, elective and/or emergency surgeries):

_____

_____

FAMILY HISTORY: (Please check any condition that is common in your blood relatives)

☐ Heart problems ☐ Diabetes ☐ Stroke ☐ DVT or blood clots ☐ Prolonged bleeding history
☐ Problems with anesthesia ☐ Anesthesia allergy ☐ High blood pressure ☐ Autoimmune disorder

_____ _____
Patient Signature **Date**

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www.WestlakePlasticSurgery.com