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HOLZMAN PLASTIC SURGERY

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NAME: _____ DATE OF BIRTH: _____

REASON FOR YOUR CONSULTATION TODAY:

PLEASE LIST ALL MEDICATIONS (INCLUDING OVER THE COUNTER, VITAMINS, HERBAL SUPPLEMENTS) THAT ARE TAKEN ON A REGULAR BASIS:

_____

PLEASE LIST ALL DRUG ALLERGIES OR ADVERSE DRUG REACTIONS:

PLEASE LIST ANY MEDICAL CONDITIONS:

DO YOU HAVE ANY PERSONAL MEDICAL HISTORY OF:

____ Diabetes	____ Hepatitis, Type___	____ Anemia	____ Sun Sensitivity
____ Cancer	____ Thyroid Condition	____ Ulcers	____ Poor Wound Healing
____ Asthma	____ Kidney Disease	____ Hives	____ Emotional Disorder
____ Emphysema	____ Cystic Breasts	____ Keloids	____ Sinus Problems
____ Tuberculosis	____ Heart Disease	____ Eczema	____ Cold Sensitivity
____ Lung Disease	____ High Blood Pressure	____ Arthritis	____ Glasses/Contacts

____ Lupus or other Connective Tissue Disease, specify_____

Do you have any past surgical history or previous hospitalizations? Yes_____ No_____
Please list with dates and reasons:

Do you have a history of excessive bleeding or bruising: Yes _____ No____
If yes, please explain:
_____
Do you take Aspirin on a regular basis? Yes_____ No_____
Do you smoke, vape or use any nicotine product? Yes_____ No_____ If so, how much? _____
Do you drink alcohol? Yes_____ No_____ If so, how much? _____
Would you like information about the medical grade skincare products that we offer? Yes_____ No ____