MICHAEL A. PERSKY, M.D., F.A.C.S.
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COSMETIC AND FACIAL PLASTIC SURGERY
PATIENT MEDICAL HISTORY

Patient Name: _____ **Height:** _____ **Weight:** _____ **Age:** _____

List Current Medications (including over the counter/vitamins/supplements etc) : _____

_____

_____

Are you allergic or have had a reaction to the following:

Aspirin/Ibuprofen/Tylenol	( ) No	( ) Yes
Latex or Metals	( ) No	( ) Yes
Codeine/Vicodin/any sedatives	( ) No	( ) Yes
Penicillin/Antibiotics	( ) No	( ) Yes

If YES, please specify: _____
Other: _____

Anesthesia Reactions:

Local	( ) No	( ) Yes
General	( ) No	( ) Yes
Topical	( ) No	( ) Yes

If YES, please specify: _____
Family history of reaction: _____

History of ANY cosmetic/medical surgeries: **Date:**

_____ _____
_____ _____
_____ _____

Circle what applies: Botox Xeomin Dysport Belotero Radiesse Restylane Perlane Juvederm Sculptra Laser Peels Others _____

Social History

Smoking	( ) No	( ) Former - Date of quitting	_____	( ) Yes - Packs/Day _____
Alcohol	( ) No	( ) Occasional/drinks per week	_____	( ) Recovering
Tanning beds	( ) No	( ) Yes, how often	_____	
Exercise	( ) No	( ) Yes, how often	_____	
Recreational drugs	( ) No	( ) Yes, please specify	_____	

Check YES or NO to indicate whether or not you have had or now have the following conditions or treatments

Heart Attack	( ) No	( ) Yes	Hiatial Hernia	( ) No	( ) Yes
Heart Condition	( ) No	( ) Yes	Keloids	( ) No	( ) Yes
Mitral Valve	( ) No	( ) Yes	Lupus	( ) No	( ) Yes
Artificial Heart Valve	( ) No	( ) Yes	Emphysema	( ) No	( ) Yes
Chest Pain (Angina)	( ) No	( ) Yes	Asthma	( ) No	( ) Yes
Congenital Heart disease	( ) No	( ) Yes	Shortness of Breath	( ) No	( ) Yes
Stroke	( ) No	( ) Yes	Hay Fever	( ) No	( ) Yes
High Blood Pressure	( ) No	( ) Yes	Sinusitis	( ) No	( ) Yes
Low Blood Pressure	( ) No	( ) Yes	Cold Sore (EVER)	( ) No	( ) Yes
Rheumatic Fever	( ) No	( ) Yes	Ulcers	( ) No	( ) Yes
Digestion Reflux	( ) No	( ) Yes	Migraines	( ) No	( ) Yes
Kidney Problems	( ) No	( ) Yes	Blackout Spells	( ) No	( ) Yes
Liver Disease	( ) No	( ) Yes	Depression/Anxiety	( ) No	( ) Yes
Tuberculosis	( ) No	( ) Yes	Mobility Problems	( ) No	( ) Yes
Hepatitis	( ) No	( ) Yes	Cancer	( ) No	( ) Yes
Jaundice	( ) No	( ) Yes	Type:		
Diabetes	( ) No	( ) Yes	Date:		

If yes, specify: _____ Any other medical conditions: _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

Signature: _____ **Date:** _____