INFORMATION FOR CASE HISTORY FILE

(Please complete all areas Please Print)

PAST MEDICAL HISTORY

General Health: Good_____ Fair_____ Poor_____

If not "Good" please explain: _____

Height_____ Weight_____ Date of last recent physical check up? _____

Did it include an electrocardiogram? Yes____ No____ Chest X-Ray Yes____ No____

Serious Illness (Please List) _____

PREVIOUS SURGERY (Please List)

Operation	Year	Hospital City	Surgeon's Name	Anesthesia(Local /General)

Have you had any complications from any previous surgeries? Yes_____ No_____

If "Yes" please explain_____

PERTINENT PREOPERATIVE INFORMATION

Please list all medications you are now taking (including blood thinners, aspirin, bufferin, birth control pills, diuretics (water pills), blood pressure or heart medications, tranquilizers, etc._____

Are you allergic to any medications? Yes____ No____ If yes, please explain:_____

Please check any of the following that pertain to your health:

_____Heart Problems	_____Heart Murmur
_____Lungs	_____High Blood Pressure
_____Kidneys	_____Liver Disease
_____Herpes	_____HIV

Do you require large amounts of local anesthetic for medical procedures?	Yes___No___
Have you ever had a bad reaction to a local anesthetic (Novocain, etc.)?	Yes___No___
Do you smoke?	Yes___No___
Do you bruise unusually easily?	Yes___No___
Do you form large scars or keloids?	Yes___No___
Do you have, or have you had any significant emotional problems?	Yes___No___
Have you ever had psychiatric care or been advised to see a psychiatrist?	Yes___No___

Signature_____

Relationship to Patient (Self, Mother , etc.)_____

SIGNATURE AUTHORIZATION

ASSIGNMENT: I hereby assign my insurance benefits to be paid directly to DESERT PLASTIC SUGERY. I am financially responsible for the non-covered services.

Signature_____ Date_____

RELEASE: I authorize DESERT PLASTIC SURGERY to release to my insurance carrier(s) any information required to process this claim.

Signature_____

I request that payment of authorized Medicare benefits be made on my behalf to DESERT PLASTIC SURGERY to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature_____ Date_____

Diplomate American Board of Plastic Surgery