

RAMIRO MORALES JR., M.D. FACS

Plastic and Reconstructive Surgery

PATIENT NAME <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF BIRTH	AGE	MARITAL STATUS
ADDRESS	APT	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	
CITY AND STATE	ZIP CODE	<input type="checkbox"/> CELL PHONE	<input type="checkbox"/> BEEPER	
E-MAIL ADDRESS		SOCIAL SECURITY		
PLACE OF EMPLOYMENT	ADDRESS	OCCUPATION	HOW LONG WORKING THERE?	
EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER		

WHAT PROCEDURE (S) ARE YOU INTERESTED IN? _____

HOW WERE YOU REFERRED TO US? _____

PAST MEDICAL HISTORY

General Health EXCELLENT GOOD FAIR POOR

Height _____ Weight _____ Most you have ever weighed, _____

Weight change in past year _____

Date of most recent physical checkup? _____ Electrocardiogram? _____ Chest X-Ray? _____

Name and Address of Doctor _____

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD:

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergy's | <input type="checkbox"/> Dry Eye | <input type="checkbox"/> Liver Disease/hepatitis/jaundice |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mental Disease or Psychiatric Care |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Seizure Disorder/Epilepsy |
| <input type="checkbox"/> Blood Transfusion Reaction | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Disease, Hives, Eczema or Rash |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Irregular/Fast Heartbeat | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Keloids | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Ulcers |
| | | <input type="checkbox"/> Other |

MEDICATIONS, DRUGS

Please list all medications you are now taking and their dosages (including aspirin or any medication containing aspirin, birth control diuretics (water pills), blood pressure or heart medications, anticoagulants (blood thinners), steroids, antibiotics, tranquilizers, hormones, etc.)

MEDICATION	DOSE	HOW OFTEN

FAMILY HISTORY: List immediate family members either deceased (with cause of death and age) or living with serious illness:
