RM | ROBERT MORIN MD
PLASTIC SURGEON

1. Do you have any **medical problems**?
Please list all medical problems in the space below.

2. Do you take any **medications**?
Please list all medications, vitamins and herbal supplements in the space below.

3. Do you take any **blood thinning medications** (aspirin, Coumadin, Plavix)? ___ YES ___ No
If yes, which blood thinning medication do you take?

4. Have you ever had any **surgery** before?
Please list all previous surgeries and the approximate dates in the space below.

5. Do you have any **allergies** to any medications?
Please list all medication allergies AND the **type of reaction** to each medication in the space below.

6. Do you have any medical problems in your **family**. Please list any medical problems in your immediate family (mother, father, sister, brother, son or daughter only) below.

7. Do you **smoke** cigarettes or use any other nicotine containing products?
YES___ No___ If yes, which product? _____ how many per day? _____ and for how many years?_____? If you quit, how long ago?_____
Do you drink **alcohol**?
YES ___ No __ If yes, how often?_____
Do you use any other **recreational drugs**? Please answer this honestly as certain recreational drugs are extremely dangerous when combined with general anesthesia.
YES ___ No ___ If yes, which drug and how often? _____

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8. Is there anything else bothering you today? YES____ No____
Please include all body **systems** including but not limited to nausea, vomiting, diarrhea, shortness of breath, fevers, chills, headache and chest pain.

9. What is your **height**? _____ What is your **weight**? _____

10. Have you ever had an eating disorder or have you ever taken diet or weight reduction pills?
YES ____ No ____

11. Are there any other medical problems you have that are not addressed by this form?
YES ____ No ____

12. Is there anything you would like to discuss with Dr. Morin today privately?
YES ____ No ____

13. Have you seen a **primary care doctor** in the past year?
YES ____ No ____
If YES, primary doctor's name _____ phone number _____

13. **Female** questions
Are you pregnant or breast-feeding? Yes ____ No ____
Are you taking birth control pills? Yes ____ No ____
Are you planning to become pregnant in the future? Yes ____ No ____
Are you planning to breast feed in the future? Yes ____ No ____
What was the date of your last mammogram (if applicable)? _____
How many times have you been pregnant? _____
How many times have you given birth? _____

14. **Signature**
I have provided a complete and accurate overview of my current medical problems and my past medical history to the best of my knowledge. I understand that this information is important in guiding my medical and surgical care and I understand that omissions and inaccuracies can increase my risk of medical and surgical complications.

Signature

Printed Name

Date