THE Julian Institute
OF PLASTIC SURGERY
Dr. Marc Polecritti, D.O.

Medical History

Name:_____ D.O.B._____ Age:_____ Ht:_____Wt:_____Male____/Female____

Reason for your visit: _____

Medication Allergies Please list medical allergies and type of reaction.

1_____ 2_____ 3_____ 4_____ 5_____ 6_____

Type of reaction: _____

Current Medications (including vitamins, herbals, and supplements)

1._____dose_____ 5._____dose_____

2._____dose_____ 6._____dose_____

3._____dose_____ 7._____dose_____

4._____dose_____ 8._____dose_____

Medical History Please check all that apply.

___Anemia ___Hepatitis

___Bleeding disorders ___HIV

___High blood pressure ___Kidney disease

___Breathing problems ___Liver disease

___Diabetes ___Depression

___Heart attack(s) ___Other(please document)_____

Surgical History Please list previous surgeries and date of surgery.

1._____Date_____

2._____Date_____

3._____Date_____

4._____Date_____

Any problems with anesthesia? _____

Do you smoke? Yes___No___ If yes, how much _____ For how long _____ If you quit, when did you quit? _____

Do you use alcohol? Yes___No___ If yes, how many drinks/day/week _____
Do you use recreational drugs? Yes___No___

Please list any pertinent family medical history:

_____

_____

Have you had any previous **cosmetic surgery? If yes, please list what procedure you had and date of procedure:

Name of Primary Care Doctor_____ Who referred you to our office? _____

Please list any other physicians:_____

I certify that the above represents my complete and accurate medical and psychiatric medical conditions.

(sign)_____Date_____