MANDAL PLASTIC SURGERY CENTER P.A.

CONFIDENTIAL MEDICAL HISTORY P. 1 OF 1 (rev. 1/6/16)

PLEASE CAREFULLY READ AND COMPLETELY ANSWER ALL INFORMATION PRIOR TO SEEING THE DOCTOR

Patient Name _____Age_____ Weight __ _____ Height _____

Check the specific concerns/ procedures you wish to discuss with Dr. Mandal

☐Facelift ☐Minifacelift ☐Eyelid lift ☐Brow lift ☐Neck ☐Ear shaping ☐Nose ☐Chin ☐ Hollow Cheeks
☐Lips ☐Neck Liposuction ☐Hair /Brow transplant ☐ Skin texture/Wrinkles ☐Scars/Moles ☐Botox
☐Ultherapy skin tighening ☐ Infini Skin tightening ☐Brown spots ☐ Long Term Fillers: Bellafill
☐ Temporary Fillers: Radiesse, Restylane, Belotero, Perlane, Sculptra, Voluma, Juvederm, Sculptra
☐ SculpSure non-invasive fat reduction ☐Other_____

Have you consulted with another cosmetic doctor about similar concerns? Y/N

What is your time frame for having your procedures? ☐weeks ☐ months ☐ one year ☐2 years

☐other, please explain _____

Check ALL illnesses/symptoms you now have or have ever had in the past:

☐reaction to anesthesia ☐easy bruising/bleeding/blood clotting disorders ☐diabetes ☐tuberculosis
☐cancer ☐stroke ☐high blood pressure ☐high cholesterol ☐arthritis ☐cold sores ☐shingles
☐asthma/bronchitis/pneumonia/lung problems ☐spine problems ☐kidney problems/bladder
☐abnormal heart rhythm/pacemaker ☐coronary heart disease/heart attack/angina ☐psychiatric
☐seizures/neurologic disease ☐glaucoma/dry eye syndrome ☐HIV/ AIDS ☐headache ☐fainting history
☐mental illness/depression/anxiety/bipolar ☐hepatitis/gallstones/cirrhosis/liver disease ☐ thyroid
☐ Other_____ ☐OTHERWISE HEALTHY

Explain in detail all illnesses/symptoms checked above:_____ _____

_____

_____

List all FAMILY MEMBERS with illnesses checked above (if none, write NONE):

_____

_____

List ALL COSMETIC or PLASTIC SURGERIES and YEAR performed (if none, write NONE):

_____

_____

_____

List Any Injectable Fillers or Botox you have had_____

List Any Lasers you have had _____

List ALL other MAJOR and MINOR surgeries and YEAR performed (if none, write NONE):

_____

_____

_____

List ALL HOSPITALIZATIONS, YEAR hospitalized and reason (if none, write NONE):

_____

_____

_____

CONFIDENTIAL MEDICAL HISTORY P. 1 OF 2 (rev. 1/4/16)

Have you ever consulted with a psychologist/psychiatrist? Y/N Please explain:

_____

_____

Have you ever been a smoker? Y/N packs/day_____ years smoked_____ when did you stop? _____

Do you drink alcohol? Y/N What _____ How much per week? _____

Do you use recreational drugs? Y/N Please specify_____

List ALL allergies/side effects to products and medication AND the reaction you have (if none, write NONE)

_____

_____

_____

List ALL OVER THE COUNTER MEDICINES, VITAMINS, HERBS (if none, write NONE)

_____

_____

_____

List ALL PRESCRIPTION MEDICATIONS and the REASON for taking (if none, write NONE)

_____

_____

_____

List ALL blood thinners i.e. aspirin, vitamin E, Coumadin (If none, write NONE)_____

Any problems with local anesthesia for dental /surgical procedures? Y/N Explain _____

Have you ever used Accutane for Acne? Y/N Explain _____

Do you have dry eyes, excess tearing, irritated eyes? Y/N Explain _____

Do you get cold sores? Y/N Where?_____ What medication do you take for them?_____

Any back or neck problems that prevent you from lying flat? Y/N Explain _____

Do you have keloids or bad scars? Y/N Explain_____

Do you require antibiotics before dental work or minor procedures? Y/N Explain _____

Are you allergic to lidocaine, xylocaine, surgical tape, latex? Y/N Explain _____

Do you experience easy bleeding or bruising? Y/N Explain _____

Date of last physical exam _____ Was it normal? Y/N Date of last EKG _____ Was it normal? Y/N

Last Chest Xray _____ Was it normal? Y/N Last bloodwork ___/___/___ Was it normal? Y/N

Primary Care Doctor name & number_____

List name, reason, date for all MEDICAL SPECIALISTS seen in the past 5 years (if none, write NONE)

1)_____

2)_____

3)_____

4)_____

5)_____

The above information is true and accurate to the best of my knowledge. My medical history will be used to make important decisions about my medical care and I agree to notify my physician within 24 hours of any changes in my medical history. Patient Signature _____ Date ____/____/____