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We are dedicated to providing you with the best care possible.

Please help us do so by providing us with the following important health information. Thank you!

PATIENT NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ SEX: _____ MARITAL STATUS: _____

TYPE OF WORK: _____ # OF CHILDREN: _____

Height _____ Weight _____ Age _____

DRUG ALLERGIES? NO KNOWN DRUG ALLERGIES Yes, Please specify: _____

FOOD ALLERGIES? NO KNOWN FOOD ALLERGIES Yes, Please specify: _____

LATEX ALLERGY? YES NO ADHESIVE TAPE ALLERGY? YES NO

PRIMARY CARE PHYSICIAN _____ Date of last physical exam _____

PRIOR SURGERY Procedure _____ Year _____ Surgeon/Location _____

Procedure _____ Year _____ Surgeon/Location _____

Procedure _____ Year _____ Surgeon/Location _____

Procedure _____ Year _____ Surgeon/Location _____

FOR WOMEN

YES NO Personal or family history of breast cancer Bra size _____

YES NO Breast mass YES NO Nipple discharge YES NO Breast pain

YES NO Are you or could you be pregnant? Have you ever had a mammogram? YES NO Date of most recent _____

PREGNANCIES Year _____ Vaginal Delivery C-section Year _____ Vaginal Delivery C-section

Year _____ Vaginal Delivery C-section Year _____ Vaginal Delivery C-section

MEDICATIONS:

PRESCRIPTION: Medication: _____ Dose _____ Medication: _____ Dose _____

Medication: _____ Dose _____ Medication: _____ Dose _____

Medication: _____ Dose _____ Medication: _____ Dose _____

OVER THE COUNTER MEDICATIONS:

Medication: _____ Dose _____ Medication: _____ Dose _____

Medication: _____ Dose _____ Medication: _____ Dose _____

HERBAL/DIETARY SUPPLEMENTS:

Medication: _____ Dose _____ Medication: _____ Dose _____

Medication: _____ Dose _____ Medication: _____ Dose _____

MEDICAL HISTORY - DO YOU HAVE OR HAVE YOU EVER HAD:

YES NO Do you exercise regularly? What type _____

YES NO Heart disease (including: heart murmur, pacemaker, catheterization, stents, surgery, mitral valve prolapsed)

Specify: _____

YES NO Chest pain _____

YES NO Previous EKG/stress test/echocardiogram Date(s) _____

YES NO High blood pressure _____

YES NO Asthma _____

YES NO Hospitalizations, IF YES, how many _____

YES NO Lung disease Specify _____

YES NO Chronic cough _____

YES NO Shortness of breath _____

YES NO Sleep apnea _____

YES NO CPAP machine If YES, do you use it nightly? YES NO

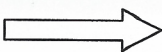
YES NO Liver disease/hepatitis/jaundice Specify _____

YES NO Diabetes Type & Date of Diagnosis _____

Do you take insulin? YES NO Last Hemoglobin A1C level _____

YES NO Are you on a special diet? Specify _____

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- YES NO Recent weight loss? If yes, was it purposeful? YES NO How much weight loss? _____
 YES NO Anemia _____
 YES NO Epilepsy/Seizures/Stroke/Neurological problems Specify _____
 YES NO Autoimmune disorders/connective tissue disorders/lupus/sarcoid Specify _____
 YES NO Psychological conditions (depression/anxiety, bipolar, schizophrenia, etc.) Specify _____
 YES NO Thyroid or goiter problems Specify _____
 YES NO Bowel/colon disease or problems Specify _____
 YES NO Frequent heartburn/indigestion, esophageal reflux, hiatal hernia _____
 YES NO Glaucoma _____
 YES NO Dry eyes _____
 YES NO Use eye drops _____
 YES NO Back and/or neck problems Specify _____
 YES NO Hepatitis If yes, type (A, B, C)? _____ Date diagnosed _____
 YES NO HIV If yes, date diagnosed _____
 YES NO MRSA If yes, date diagnosed _____
 YES NO Past/present carrier of other contagious/infectious disease Specify _____
 YES NO Exposure to communicable diseases in the past 3 weeks Specify _____
 YES NO Personal or family history of deep venous thrombosis (DVT, blood clots in legs or lungs) _____
 YES NO Personal history of bleeding or clotting abnormality (e.g. Factor V Leiden, lupus anticoagulant) _____
 YES NO Family history of bleeding or clotting abnormality (e.g. Factor V Leiden, lupus anticoagulant) _____
 YES NO History of blood transfusions Specify _____
 YES NO Do you or have you ever smoked? Amount per day _____ How many years _____ Year quit _____
 YES NO Use(d) smokeless tobacco How many years _____ Year quit _____
 YES NO Use(d) recreational drugs types(s) _____ How much _____ How many years _____
 YES NO Use(d) alcohol type(s) _____ How much _____
 YES NO Been treated for substance abuse type(s) _____ When _____
 YES NO Steroid use in the past 12 months Specify _____
 YES NO Keloids or unusually large scars _____
 YES NO Malignant Hypothermia _____
 Any significant family history of disease If yes, please explain: _____

ANESTHESIA HISTORY

- YES NO Have you ever had a reaction to a regional or local anesthesia injection? If yes, specify _____
 YES NO Have you ever had a general anesthesia? _____
 YES NO Have you ever had problems with anesthesia? Specify _____
 YES NO Have members of your family had problems with anesthesia? Specify _____

DO YOU HAVE OR WEAR ANY OF THE FOLLOWING?

- YES NO Dentures
 YES NO Eye Glasses
 YES NO Contact Lens

I HAVE ANSWERED ALL OF THESE QUESTIONS FULLY AND TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I SHOULD INFORM MY PHYSICIAN IF I EXPERIENCE ANY NEW HEALTH ISSUES OR IF THE STATUS OF MY EXISTING HEALTH ISSUES CHANGES.

Patient Signature

Date

Parent/Guardian/Next of Kin (if patient unable to sign) Relationship

FOR OFFICE USE ONLY

Patient is NOT eligible for the treatments and products checked below. All others are authorized. Skin type: _____

Laser/Treatments:	Products:	Injectable:
<input type="checkbox"/> Permanent laser hair reduction	<input type="checkbox"/> Facial w/chemical peel	<input type="checkbox"/> Botox
<input type="checkbox"/> Laser vein therapy	<input type="checkbox"/> Latisse <input type="checkbox"/> Hydroquinone	<input type="checkbox"/> Dermal Fillers
<input type="checkbox"/> Intense pulsed light treatment (IPL)	<input type="checkbox"/> Salicylic Acid	<input type="checkbox"/> Sub dermal – local injectable
<input type="checkbox"/> SmartSkin Fractional CO2	<input type="checkbox"/> Glycolic Acid	<input type="checkbox"/> Dental block
<input type="checkbox"/> Ultherapy	<input type="checkbox"/> Blue Peel	<input type="checkbox"/> Topical Anesthetic
<input type="checkbox"/> Microdermabrasion	<input type="checkbox"/> Retin-A	<input type="checkbox"/> Scar Therapy w/Kenalog
<input type="checkbox"/> Dermaplaning	<input type="checkbox"/> Melange Peel	<input type="checkbox"/> Schlerotherapy

(PHYSICIAN ONLY) FORM REVIEWED WITH PATIENT _____

_____, M.D. Date _____

Updated _____ Patient Signature _____

Physician Signature _____