JAMES M. NACHBAR, M.D., F.A.C.S.

Health History

NAME: _____

(Cosmetic)

DATE: _____

WHAT IS THE PURPOSE OF THIS CONSULTATION?

Describe what you do not like or what you would like corrected by plastic surgery, and what your goals are in regard to your desired correction:

HAVE YOU EVER CONSULTED A PLASTIC SURGEON?

Please describe, including dates.

WERE YOU SATISFIED WITH THE RESULTS OF ANY PLASTIC SURGERY YOU MAY HAVE HAD?

PLEASE LIST ANY SURGERY (OR SURGERIES) YOU HAVE HAD, WHETHER PLASTIC SURGERY OR NOT.

PLEASE DESCRIBE REASONS FOR ANY OTHER HOSPITAL ADMISSIONS.

PLEASE DESCRIBE ANY OTHER MEDICAL PROBLEMS YOU HAVE HAD.

PLEASE DESCRIBE YOUR HEALTH:

WEIGHT_____ HEIGHT_____

HAVE YOU EVER HAD ANY MAJOR OR SERIOUS INJURIES? (Yes / No)

HAVE YOU EVER RECEIVED TREATMENT FOR A MENTAL CONDITION, EMOTIONAL PROBLEM OR DEPRESSION? (Yes / No)

(Please describe and list dates.)

WHAT MEDICATIONS HAVE YOU TAKEN IN THE LAST SIX MONTHS?

(Please do not omit anything because medications used during and after surgery may interact adversely. Be sure to include Birth Control Pills, Diet pills, Phen Fen, Redux, aspirin or ibuprofen containing drugs, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, nitroglycerin, Isordil, Inderal, other heart medications, Lasix, other diuretics or water pills, high blood pressure medications, Coumadin, Persantine, tranquilizers, sleeping pills, anti-depressants, pain pills or shots, epilepsy medications)

Medications	Dosage	Frequency	Purpose

HAVE YOU EVER HAD A BAD REACTION OR AN ALLERGIC REACTION TO ANY MEDICATIONS? (Yes / No)

(Please describe reaction and from which medications.)

HAVE YOU EVER SMOKED? (Yes / No)

For how long? _____Years. How many packs per day? _____

If you no longer smoke, when did you quit? _____