# *Usal Cosmetic Surgery Center*
# *Medical History Information*

**Please fill out the following information. We will assist you with any questions.**

**Name:** _____ **Date:** _____
Nombre Fecha

**Present Complaint:** _____ **Age:** _____
Razon para la visita Edad

**Height:** _____ **Weight:** _____
Estatura Peso

**Please check all allergies:**

**None:** _____ **Local/General Anesthesia:** _____
Ninguno Anastesia Local/ General

**Sulfa drugs:** _____ **Surgical Tape:** _____
Drogas Cinta Quirurgica

**Latex:** _____ **Iodine/Shellfish:** _____
Latex Yodo/Marisco

**Penicillin:** _____ **Hay fever/Seasonal:** _____
Penicillina Polinosis/Alergia Estacional

**Past Medical History:**
**Do You Have Any of the Following? (Please check all that apply)**

**Asthma:** □
El Asma
**Hypertension:** □
Hypertension
**Bleeding Disorder:** □
Desorden Sangriento
**Diabetes:** □
Diabetes
**Kidney Disease:** □
Enfermedad renal
**Seizures:** □
Ataque Epileptico
**Heart Disease:** □
Enfermedades Cardiacas
**Ulcers:** □
Ulceras
**Cancer:** □
El Cancer
**Circulation Disorders:** □
Desordenes de Circulacion
**Stroke:** □
Ataque Cardiaco/El Golpe
**Blood Clots:** □
Coagulos Sangrenos

**Other Medical Problems:**

_____

**Do you smoke?** _____ **If yes, how much?** _____
Usted Fuma? Si, Cuanto?

**List all medications: (**Lista de medicamentos)

_____

_____

**List all other prior surgical procedures:** (Lista de todas las serugias previas

_____