Eskra
PLASTIC SURGERY

NAME _____ AGE _____ TODAY'S DATE_____

DO YOU HAVE ANY OF THE FOLLOWING DISEASES? (CIRCLE **YES** OR **NO**)

DIABETES	**YES / NO**	PERIPHERAL VASCULAR DISEASE	**YES / NO**
HIGH BLOOD PRESSURE	**YES / NO**	SEIZURES	**YES / NO**
HIGH CHOLESTEROL	**YES / NO**	RHEUMATOID ARTHRITIS	**YES / NO**
HEART DISEASE	**YES / NO**	FIBROMYALGIA	**YES / NO**
IRREGULAR HEARTBEAT	**YES / NO**	CHRONIC PAIN	**YES / NO**
ATRIAL FIBRILLATION -AFIB	**YES / NO**	DEPRESSION	**YES / NO**
HEART VALVE PROBLEM	**YES / NO**	DVT (BLOOD CLOTS)	**YES / NO**
ASTHMA	**YES / NO**	EASY BRUISING/BLEEDING	**YES / NO**
COPD/EMPHYSEMA	**YES / NO**	POOR SCARRING	**YES / NO**
CANCER	**YES / NO**	IF YES, TYPE OF CANCER: _____	

PLEASE LIST ANY OTHER MEDICAL PROBLEMS: _____

_____

LIST ANY PREVIOUS SURGERIES: _____

_____

DO YOU HAVE? ARTIFICIAL HEART VALVE **YES / NO** PACEMAKER/DEFIBRILLATOR **YES / NO**

DO YOU TAKE? ASPIRIN **YES / NO** COUMADIN **YES / NO** PLAVIX **YES / NO**

LIST ALL OTHER MEDICATIONS (INCLUDE DOSAGES): _____

_____

DO YOU TAKE? FISH OIL **YES / NO** VITAMIN E **YES / NO** GARLIC **YES / NO**

MEDICATION ALLERGIES: _____

_____

DO YOU SMOKE? **YES / NO**

IF YOU USED TO SMOKE, HOW LONG HAS IT BEEN SINCE YOU QUIT: _____

ANY OTHER TOBACCO USE? (VAPE, CIGARS, PIPE, CHEW) **YES / NO** NICOTINE REPLACEMENT? **YES / NO**