MIDDLESEX PLASTIC SURGERY CENTER
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Middletown, CT 06457

# MEDICAL QUESTIONNAIRE

Name, TYPE: _____
DOB: _____ Height: _____ Weight: _____

All **Medical Conditions** you have been treated for or diagnosed with:

_____ _____
_____ _____
_____ _____
_____ _____

All **Medications** you take, doses:

_____ _____
_____ _____
_____ _____
_____ _____

Any **Surgeries** you have had, year:

_____ _____
_____ _____
_____ _____

Any **Drug Allergies** you have:
Drug: _____ Reaction: _____
_____ _____
_____ _____

Family history of heart disease, cancer, diabetes?
In whom? _____ _____
_____ _____

| | | | |
|---|---|---|---|
| Do you smoke? | Yes: ___ | No: ___ | How many packs/day? |
| Do you drink alcohol? | Yes: ___ | No: ___ | How many drinks/night? |
| Do you have seizures? | | | Yes: ___ No: ___ |
| Do you bleed easy? | | | Yes: ___ No: ___ |
| Have you ever had a reaction to anesthesia? | | | Yes: ___ No: ___ |
| Do you have any keloids/hypertrophic scars? | | | Yes: ___ No: ___ |
| Have you ever had psychiatric care? | | | Yes: ___ No: ___ |
| Have you seen another plastic surgeon for this issue? | | | Yes: ___ No: ___ |
| Do you get frequent infections? | | | Yes: ___ No: ___ |

Signature of Patient: _____ Date: _____