ADVANCED PLASTIC SURGERY CENTER
TALAL A. MUNASIFI, MD, FACS

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MEDICAL HISTORY

Primary Care Physician:	Phone Number:

Have you experienced any of the following: (check yes if applicable)

☐Abnormal blood pressure	☐Heart murmur	☐Rheumatic fever
☐Anemia/blood disorder	☐Heart palpitations	☐Skin disease
☐Anxiety/depression	☐Hepatitis (if yes, please circle: A, B, or C)	☐Sleep problems
☐Arthritis/joint pain	☐Hiatal hernia (reflux)	☐Stroke
☐Asthma	☐High cholesterol	☐Thyroid disease
☐Autoimmune disease	☐HIV/AIDS	☐Urinary infections
☐Blood transfusions	☐Jaundice	☐Varicose veins/phlebitis
☐Bowel disease	☐Kidney disease	☐Vascular disease
☐Cancer	☐Liver disease	☐Weight gain
☐Diabetes	☐Mental illness	☐Weight loss
☐Epilepsy/Neurological disease	☐Osteoporosis	☐Other:
☐Headaches	☐Peptic ulcer	

SOCIAL HISTORY

Smoker (if yes, # of years):	Smoking (Cig./Day):	Street Drugs:
Alcohol (oz/week):	Coffee(Cups/Day):	Herbal Supplements:

Are you taking any medication, if so which ones?

Are you allergic to any medication, drugs, or local anesthetic?

PREVIOUS HISTORY

Please list any previous cosmetic procedures (surgical, injections, laser treatments, etc.):

Are there any physical conditions we should know about?

May we request medical records, if needed? ☐Yes ☐No

WOMEN (ONLY)

Are you pregnant? ☐Yes ☐No	Are you nursing? ☐Yes ☐No
Signed:	Date:

Relationship (if not patient):