Carolina Plastic Surgery & Laser Center, P.A.
1721 Ebenezer Road, Ste 205
Rock Hill, SC 29732

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Name:_____ Reason for visit:_____ Age_____
Primary Care Doctor:_____

Height_____ Weight_____ Blood Pressure_____ Pulse_____

Patient Medical: Please circle if you have ever had the following

Asthma/CPAP	bleeding disorder	breast cancer	cancer
Chest pain/tightness	diabetes	eczema	heart disease
Heart murmur	hepatitis	high blood pressure	hives
Kidney stones	skin cancer	skin disease	stroke
Thyroid disorder	tuberculosis	ulcers	x-ray therapy

Urinary tract infection Other_____
Do you have Sleep Apnea_____
Past surgeries:
Surgery/hospitalization and Date/Any problems_____
_____
_____

Family History: afflicted family member/immediate family only

Abnormal bleeding_____	heart disease_____
Abnormal clotting_____	hemophilia_____
Adopted_____	high blood pressure_____
Anesthesia Pros_____	kidney disease_____
Autoimmune disorders_____	liver disease_____
Brain tumor_____	lung cancer_____
Breast cancer_____	other cancer_____
Cleft lip/palate_____	ovarian cancer_____
Diabetes_____	prostate cancer_____
Endocrine disease_____	skin cancer_____
Hearing loss_____	von willebrand_____

Patient allergies and reactions_____

What medications are you currently

_____
_____
_____

Do you drink alcohol_____ Do you smoke_____ Do you use illegal drugs_____

Do you have regular periods_____Are you going through menopause____ Are you lactating or pregnant_____ During Pregnancy did you have hyper pigmentation of the face_____

Patient signature:_____ Date_____