## Medical Information

| | | | |
|---|---|---|---|
| Heart Disease | ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No |
| High Blood Pressure | ☐ Yes ☐ No | Blood Disease | ☐ Yes ☐ No |
| Asthma | ☐ Yes ☐ No | Kidney Disease | ☐ Yes ☐ No |
| Lung Disease | ☐ Yes ☐ No | Jaundice | ☐ Yes ☐ No |
| Recent sore throat | ☐ Yes ☐ No | Glaucoma | ☐ Yes ☐ No |
| Cold | ☐ Yes ☐ No | Cancer | ☐ Yes ☐ No |
| Flu | ☐ Yes ☐ No | Have you ever been treated for Anemia? | ☐ Yes ☐ No |
| Bronchitis | ☐ Yes ☐ No | Do you bruise easily? | ☐ Yes ☐ No |
| Have you had a recent chest x-ray? | ☐ Yes ☐ No | Have you ever had any problems with bleeding | ☐ Yes ☐ No |
| Have you had a recent electrocardiogram? | ☐ Yes ☐ No | Please list allergies: | |
| Hay fever | ☐ Yes ☐ No | Have you or any relative ever had a bad reaction from General or Local Anesthetic? | ☐ Yes ☐ No |
| Do you suffer from allergies? | ☐ Yes ☐ No | Do you have a latex allergy? | ☐ Yes ☐ No |
| **Do you or have you ever taken any of the following drugs:** | | | |
| Aspirin, Excedrin, Advil, Aleve, Motrin, Midol, Pamprin, Ibuprofen | ☐ Yes ☐ No | Water pills | ☐ Yes ☐ No |
| Tranquilizers | ☐ Yes ☐ No | Antihistamines | ☐ Yes ☐ No |
| Pain pills | ☐ Yes ☐ No | Blood Pressure Pills | ☐ Yes ☐ No |

What medications are you presently taking? _____

Do you take ANY non-prescription medications, vitamins or herbs? .....Yes___No___

**If yes, which?** _____

Have you ever had any serious illness or accident? .....Yes___No___

If yes, explain _____

**Do you:**

| | | |
|---|---|---|
| Smoke? | ☐ Yes ☐ No | How much, how often? |
| Drink Alcohol? | ☐ Yes ☐ No | How much, how often? |
| Recreational Drugs? | ☐ Yes ☐ No | How much, how often? |

Have you had any previous surgeries, including plastic surgery? If so, what kind, where, when. .....Yes___No___

Explain_____

Have you ever consulted a professional for emotional problems? .....Yes___No___

When was your last complete physical examination? _____

Name of your personal physician_____ Phone_____

Do you wear glasses? .....Yes___No___

Height_____ Weight_____

Are you presently or have you ever been involved in any legal suit or malpractice suit? .....Yes___No___

If yes, please explain_____

**IMPORTANT FINANCIAL TERMS and RELEASE:**

I understand that **I am responsible for all services provided** and that **full payment for surgery is due two (2) weeks prior to your procedure**. Deposits are **non-refundable** and any credits will be honored for one (1) calendar year. Any amount 30 days past due will subject to 1.5% interest **per month**. I will also be responsible for any collection cost, court costs, filing fees and attorney fees. I authorize the release of any or all of my medical records to any health care provider, hospital or other institution as deemed necessary by Andrew P. Amunategui, MD and/or myself.

**My signature below indicated that all of the information listed above is correct and that I agree to the terms listed above.**

Patient Signature_____ Date _____

Witness _____ Date _____