# Moises Salama M.D.

Board Certified Plastic Surgeon

www.epsmiami.com

## Health Information as of ( )

(Please Print Legibly & Fill In or Correct All Fields)

**Patient:** **Email address:**

**Address:** **Apt. #** **City** **State** **Zip Code**

**Phone:** **Cell:**
**(000) 000-0000** **SSN:** **DOB:**

What surgery are you considering?
Breast Body Face Eyes Botox Laser Other:

Height: Weight:

Referred by: REALSELF Billboard Ad Google Internet Friend: Other:

Have you ever been involved in any medical litigation?

Occupation:

Emergency Contact: Phone: Relationship:

DO YOU NOW OR HAVE YOU EVER HAD……….. ( You must circle an answer for each individual item)

| Condition | | | Condition | | |
|---|---|---|---|---|---|
| Abdominal Bleeding | YES | NO | Glaucoma or Eye Problems | YES | NO |
| Abnormal Bleeding after Tooth Extraction | YES | NO | Goiter or Thyroid Disorders | YES | NO |
| Abnormal EKG | YES | NO | Glaucoma or Eye Problems | YES | NO |
| Airway Obstruction (Nasal) | YES | NO | Goiter or Thyroid Disorders | YES | NO |
| Alcoholism or Drug Dependency | YES | NO | Hay Fever | YES | NO |
| Arthritis | YES | NO | Heart Disease | YES | NO |
| Asthma | YES | NO | Heart Failure | YES | NO |
| Black Outs | YES | NO | Heart Murmur | YES | NO |
| Bleeding Tendency or Disorder | YES | NO | Hemorrhoids | YES | NO |
| Blood Pressure Abnormalities | YES | NO | Hepatitis | YES | NO |
| Blood Transfusion | YES | NO | High Blood Pressure / Hypertension | YES | NO |
| Breast Cancer | YES | NO | Hives | YES | NO |
| Bronchitis | YES | NO | Insomnia | YES | NO |
| Cancer | YES | NO | Kidney Disorder | YES | NO |
| Chest Pain | YES | NO | Kidney or Renal Disease | YES | NO |
| Chest Pain / Tightness | YES | NO | Kidney Stones | YES | NO |
| Cirrhosis of the Liver | YES | NO | Loose teeth | YES | NO |
| Colitis | YES | NO | Missed or irregular last menstrual period | YES | NO |
| Cosmetic bonding to teeth | YES | NO | Nervous Breakdown | YES | NO |
| Coughing or Spitting of Blood | YES | NO | Nervous Disorder | YES | NO |
| Dentures, Bridges, Capped Teeth or Crowns | YES | NO | Nipple Discharge (Apart from Normal Lactation) | YES | NO |
| Diabetes | YES | NO | Palsy or Paralysis | YES | NO |
| Digitalis Treatment | YES | NO | Piercing other than the Ears | YES | NO |
| Drug Habit | YES | NO | Pneumonia | YES | NO |
| Eczema | YES | NO | Positive Blood test for: HIV, AIDS, Hepatitis | YES | NO |
| Emphysema | YES | NO | Problem Constipation | YES | NO |

PLASTIC SURGERY

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| Condition | | |
|---|---|---|
| Esophageal Varices | YES | NO |
| Fracture of Neck or Spine | YES | NO |
| Frequent Indigestion | YES | NO |
| Gallstones or Gallbladder Trouble | YES | NO |
| Gastritis | YES | NO |
| Skin Cancer | YES | NO |
| Skin Disease | YES | NO |
| Skin Disorders | YES | NO |
| Smokers Cough | YES | NO |
| Stroke | YES | NO |
| Tarry or Bloody Bowel Movements | YES | NO |
| Thyroid Disorder | YES | NO |
| Psychiatric Hospitalizations or Care | YES | NO |
| Rheumatic Fever | YES | NO |
| Seizures or Convulsions or Fainting Spells | YES | NO |
| Self-Destructive Tendencies | YES | NO |
| Shortness of Breath | YES | NO |
| Thyroid Problems | YES | NO |
| Tuberculosis | YES | NO |
| Ulcers | YES | NO |
| Visual Disturbances | YES | NO |
| Vomiting Blood | YES | NO |
| Xray Therapy | YES | NO |
| Yellow Jaundice | YES | NO |

HAS ANYONE IN YOUR FAMILY EVER HAD….

| | | |
|---|---|---|
| History of Cancer | YES | NO |
| History of Heart Troubles | YES | NO |
| History of Strokes | YES | NO |
| Bleeding Problems | YES | NO |
| Anesthesia Problems | YES | NO |

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, and weight loss drugs. **Include over-the-counter medications.**

_______________________________________________________________________________

2. Do you have an allergic reaction to any medication? ❒ Yes ❒ No Which? ______________________
3. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?

   ❒ Yes ❒ No If yes, when and where? ______________________________________________
4. Have you ever been on cortisone or steroid treatment? ❒ Yes ❒ No When? ____________________
5. Do you smoke? ❒ Yes ❒ No If so, how much? ______________ For how long? ______________
6. Are you pregnant? ❒ Yes ❒ No When was you last normal menstrual period? __________________

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8. Have you ever been under psychiatric care? ❒ Yes ❒ No When? ______________Why? __________
9. Have you had any recent blood work done? ❒ Yes ❒ No Where? __________________________
10. Is there anything else you think the doctor should know? ___________________________________

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______________________________________________________________________

11. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:
(include where, when and why for each surgery)
SURGICAL OPERATIONS: ________________________________________________
HOSPITALIZATIONS: ___________________________________________________

12. Have you been on any other cosmetic surgery consultations? If yes, with whom?
______________________________________________________________________