Gregory M. Fedele, M.D., F.A.C.S.
Center for Plastic & Cosmetic Surgery
35040 Chardon Rd., Ste. 101, Bldg. IV
Willoughby Hills, OH 44094

Reason for visit_____ **Date**_____

Age_____ **Race**_____ **Sex**_____ **Height**_____ **Weight**_____

Medical History:

Do you have any **medical conditions** in the following Areas? If Yes, please explain

Yes No

- ☐ ☐ Anemia_____
- ☐ ☐ Asthma_____
- ☐ ☐ Bleeding Disorders_____
- ☐ ☐ Blood Pressure(high)_____
- ☐ ☐ Blood Clot (leg or lung)_____
- ☐ ☐ Breathing Problems_____
- ☐ ☐ Cancer_____
- ☐ ☐ Circulation Problems_____
- ☐ ☐ Cold Sores/Herpes_____
- ☐ ☐ Depression_____
- ☐ ☐ Diabetes_____
- ☐ ☐ Eating Disorders_____
- ☐ ☐ Eye Problems_____
- ☐ ☐ Fainting_____
- ☐ ☐ Gastrointestinal Problems_____
- ☐ ☐ Heart Problems_____
- ☐ ☐ Hepatitis_____
- ☐ ☐ HIV_____
- ☐ ☐ Hormonal Changes_____
- ☐ ☐ Joint Replacements_____
- ☐ ☐ Kidney Disease_____
- ☐ ☐ Liver Disease_____
- ☐ ☐ Migraines_____
- ☐ ☐ Mitral Valve Prolapse_____
- ☐ ☐ Antibiotic for MVP_____
- ☐ ☐ Seizures_____
- ☐ ☐ Sickle Cell_____
- ☐ ☐ Stroke_____
- ☐ ☐ Thyroid Disease_____
- ☐ ☐ Other_____

_____

_____

Please list all prior **surgeries** that you have had:

1._____
2._____
3._____
4._____
5._____
6._____
7._____

Problems with anesthesia? ☐ Yes ☐ No
Explain:_____

Patient Name:_____

Please list your current **medications** (include over the counter):

1._____
2._____
3._____
4._____
5._____
6._____

Do you have any **allergies** to medications?
☐ No ☐ Yes (Please list):
1._____
2._____
3._____

Women:
Mammogram ☐Yes ☐No Date:_____
Are you pregnant at this time? ☐ Yes ☐ No
Are you currently breast feeding ☐ Yes ☐ No
When was your last menstrual period?_____
Number of pregnancies:_____
Number of children_____ Caesarean section_____

Breast Enhancement Patients Only:
Current bra size_____Desired bra size_____

Family History:
Breast Cancer ☐ Yes ☐ No
If yes, Mother___Aunt___Grandmother___
Other:_____
Skin Disease/Cancer? ☐ Yes ☐ No
If yes, relationship_____

Social History:
Do you smoke? ☐ Yes ☐ No
How much_____How long_____
Do you drink alcohol? ☐ Yes ☐ No
☐ Occasional ☐ Never
History of alcoholism? ☐ Yes ☐ No
Do you ever use illicit drugs? ☐ Yes ☐ No

Referred by:
☐ Cleveland Magazine
☐ Friend
☐ Internet
☐ Phone Book
☐ Physician_____
☐ Other_____

Reviewed by:_____