South Florida Center for Cosmetic Surgery
Client Medical Questionnaire

Date:________________
Name:___________________________(as it appears on Driver's License)
Address: _________________________
City:_________________ State:_________________ Zip:_________

Gender: _______________ Birth Date:_______________ Age:_______
Home phone number:____________________ Cell phone: _____________

Emergency Contact Name: _____________________________________
Home phone number: ________________
Cell phone: _________________________

Are you allergic to any medication? Y or N
If yes, please specify: ____

Are you currently taking any medications? Y or N
If yes, please list:
***Medication Name**, **Dose**, and **How Often** in this section:*

____

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____

Current Height: _____________ Current Weight:______________

Please Indicate if you had or have any of the following health conditions:

High/Low Blood Pressure	*Y or N*	______________________
Heart Murmur	*Y or N*	______________________
Irregular/Fast Heart Beat	*Y or N*	________________________
Mitral Valve Prolapse	*Y or N*	________________________
Blood Transfusion Reactions	*Y or N*	________________________
Angina	*Y or N*	________________________

Circulatory Problems Y or N ______________________________
Fainting Spells Y or N ______________________________
Excessive Bleeding Y or N ______________________________
Stroke Y or N ______________________________
Anxiety/Depression Y or N ______________________________
Asthma Y or N ______________________________
Bronchitis Y or N ______________________________
Pneumonia Y or N ______________________________
Tuberculosis Y or N ______________________________
Emphysema Y or N ______________________________
Ulcers Y or N ______________________________
Stomach Problems Y or N ______________________________
Rheumatic Fever Y or N ______________________________
Glaucoma Y or N ______________________________
Cataracts Y or N ______________________________
Arthritis Y or N ______________________________
Gout Y or N ______________________________
Diabetes Y or N ______________________________
Thyroid Disorder Y or N ______________________________
Kidney Disorder Y or N ______________________________
Bladder Infections Y or N ______________________________
Gall Bladder Y or N ______________________________
Liver Disease/Hepatitis/Jaundice Y or N ______________________________
Prostate Problems Y or N ______________________________
Cancer Y or N ______________________________
Other Psychiatric Disorders Y or N ______________________________

We at the South Florida Center appreciate you taking the time to complete this form. Our Clinical Director will be in contact with you regarding this information in a timely manner.