



**JAIME R. GARZA M.D.**  
TEXAS PLASTIC SURGERY

**Patient Name:** \_\_\_\_\_  
**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**MEDICAL**

|                                   |            |           |                                |            |           |
|-----------------------------------|------------|-----------|--------------------------------|------------|-----------|
| Do you or have you had:           | <b>Yes</b> | <b>No</b> |                                | <b>Yes</b> | <b>No</b> |
| Prolonged bleeding when cut       | ___        | ___       | Fainting or black out episodes | ___        | ___       |
| High blood pressure               | ___        | ___       | Ulcer disease                  | ___        | ___       |
| Heart disease or attack           | ___        | ___       | Hepatitis                      | ___        | ___       |
| Heart murmur or disorder          | ___        | ___       | Other significant illness      | ___        | ___       |
| Chest Pain or shortness of breath | ___        | ___       | - Please Describe:             |            |           |
| Fever blister or cold sores       | ___        | ___       |                                |            |           |

**SURGICAL**

Previous operation(s): \_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BLEEDING**

|                               |            |           |                                       |            |           |
|-------------------------------|------------|-----------|---------------------------------------|------------|-----------|
|                               | <b>YES</b> | <b>NO</b> |                                       | <b>YES</b> | <b>NO</b> |
| Aspirin intake past two weeks | ___        | ___       | Family history or prolonged bleeding? | ___        | ___       |
| Prolonged bleeding when cut?  | ___        | ___       | Have you had blood transfusions?      | ___        | ___       |
|                               |            |           | Reactions to blood transfusions?      | ___        | ___       |

**SCARRING**

Have you formed excessive or unsatisfactory scars in the past? **YES NO**

**ALLERGIES**

Are you allergic or have reactions to medications, drugs, or local anesthetic medication?  
\_\_\_\_\_

**CURRENT MEDICATIONS:**

List all including aspirin and birth control

Do you or have you taken Accutane? **YES NO**

|       | DOSE  | FREQUENCY TAKEN |
|-------|-------|-----------------|
| _____ | _____ | _____           |
| _____ | _____ | _____           |
| _____ | _____ | _____           |
| _____ | _____ | _____           |
| _____ | _____ | _____           |

**PERSONAL PHYSICIAN**

Name of Personal/regular physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
Business telephone: \_(\_\_\_\_)\_\_\_\_\_ Fax: \_(\_\_\_\_)\_\_\_\_\_  
Date of last physical examination: \_\_\_\_\_

**FAMILY HISTORY**

Is there a history of the following in your immediate family?

Heart disease \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Hepatitis \_\_\_\_\_

If so, please list family member

Cancer (type) \_\_\_\_\_  
Stroke \_\_\_\_\_  
Keloids \_\_\_\_\_

**PERSONAL HISTORY**

|                                      |            |           |                                 |
|--------------------------------------|------------|-----------|---------------------------------|
|                                      | <b>YES</b> | <b>NO</b> | <b>OCCASSIONALLY</b>            |
| Do you smoke?                        | ___        | ___       | ___ If yes: _____ packs per day |
| Do you drink?                        | ___        | ___       | ___                             |
| Do you use ANY drugs or medications? | ___        | ___       | ___ If yes, List: _____         |

**PATIENT SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_