Eastern Cosmetic Surgery Institute
Timothy M. Greco, M.D., P.C., F.A.C.S.
Consultation & Medical History Data

Medical History (Check appropriate Response)

☐ Yes ☐ No Would you object to this office contacting your physician for additional health information? ____

History of bleeding (indicate which): From Nose _______ In Urine _______ Vomiting blood _______ Rectum _______ Coughing Up ______ Other __________

Please answer yes or no to the following questions with additional explanation as requested.

Pharmacy Name ____ Phone Number_______________________________

☐ Yes ☐ No Are you taking medications? Please List; ____

Dosage: _______________________________ Frequency: ____

☐ Yes ☐ No Do you smoke? How much? ____

☐ Yes ☐ No Have you had a "reaction" to Anesthetic (including local Novocain, Xylocaine)? Explain _____________________________________

☐ Yes ☐ No Allergies to Medication? Please List; ____

☐ Yes ☐ No Vitamins or Herbal Supplement? Please List; ______________________________________Dosage: ________________________________

☐ Yes ☐ No Allergies to perfume, kin care or products? ____

☐ Yes ☐ No Have you ever taken Accutane? Start: _________________________ Month/Year: ___________________Stop: _______________________

☐ Yes ☐ No Heart problems? Describe: ____

☐ Yes ☐ No Vision problems? Describe: ____

☐ Yes ☐ No Thyroid problems? Medication: ____

☐ Yes ☐ No Excessive bruising? Describe: ____

☐ Yes ☐ No Excessive scarring? Describe: ____

☐ Yes ☐ No Delayed or poor healing? Describe: ____

☐ Yes ☐ No Frequent Pains: ____

☐ Yes ☐ No Stomach problems, Ulcers: ________________________ Chest or Lung problems: ____

☐ Yes ☐ No Liver or Gall Bladder problem: ___________________ Kidney or Bladder problem: ____

☐ Yes ☐ No Have you ever taken Coumadin: Dose: _________________________ How Often: ____

PLEASE TURN OVER ►

☐ Yes ☐ No Psychiatric or nerve problem: Describe: ______________________________

☐ Yes ☐ No History of High blood pressure: Medication: ______________________________

☐ Yes ☐ No Diabetes: Medication: ______________________________

☐ Yes ☐ No Poor Circulation? ______________________________

☐ Yes ☐ No Frequent Skin Infections or Rashes? ______________________________

☐ Yes ☐ No History of Fever Blisters / Cold Sores? ______________________________

☐ Yes ☐ No Severe Headaches / Dizzy Spells? ______________________________

☐ Yes ☐ No Seizures? ______________________________

☐ Yes ☐ No History of Venereal Disease/ Hepatitis/ HIV positive? ______________________________

☐ Yes ☐ No Ever been treated for Anemia? When ______________________________

☐ Yes ☐ No Do you take hormones? Start Date ______________________________

☐ Yes ☐ No Do you drink more than 6 cups of coffee a day?

☐ Yes ☐ No Do you have more than 2 alcoholic drinks a day?

☐ Yes ☐ No Do you use recreational drugs or been treated for drug addiction? When: ______________________________

☐ Yes ☐ No Ever been under the care of a psychiatrist or psychologist? When: ______________________Reason:__________________

WOMEN ONLY: When was your last menstrual period? ______________________________

MEN ONLY: Have you ever had prostate problems? ______________________________

☐ Yes ☐ No Other medical problems that have not been covered? ______________________________

☐ Yes ☐ No Do you accept the fact that every medical and surgical treatment is associated with risks and other imponderables?

☐ Yes ☐ No Do you give consent and authorized the recommended diagnostic, medical, surgical, anesthetic and other diagnostic services that the clinic deems beneficial while you are under their care?

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SIGNATURE ______________________________ **DATE** ______________________