THE AESTHETIC CENTERS
Aesthetic, Plastic and Reconstructive Surgery
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Pre-Op History and Physical Form

Patient Name: _____ DOB: _____ Todays Date: _____
Proposed Surgical Procedure: _____

_____
Date of Surgery: _____
Allergies: _____
Past Medical Illnesses: _____
Medications: _____
Social History: ❑Alcohol ❑Tobacco ❑Drugs

Review of Systems (Check box if applicable. If YES, please explain)

❑ Cardiovascular _____
❑ Dermatologic _____
❑ Endocrine _____
❑ Gastrointestinal _____
❑ Genito-Urinary _____
❑ Hematologic/Oncology _____
❑ Psychiatric _____
❑ Ophthalmologic _____
❑ Musculoskeletal _____
❑ Neurological _____
❑ Infectious _____
❑ Pulmonary _____
Details on Significant Findings: _____

Past Surgical History

Date	Surgeon	Surgery

Physical Exam

Sex	Age	Height	Weight	BP	Pulse	Resp	Temp

HEENT: ❑Normal Other _____
Heart/Cor: ❑Regular Rhythm Other _____
Chest Lungs: ❑Clear Other _____
Abdomen: ❑Normal Other _____
Skin/ Neck: ❑Normal Other _____
Is patient cleared for scheduled surgical procedure? ❑Yes ❑No, Explain _____
Comments: _____

Physician Name (Print): _____ Phone #: _____

Physician's Signature: _____ Date: _____

Immediately upon completion, please fax this form and any other requested pre-operative lab results (including EKG) to 949-398-4173. Failure to return forms at least 2 weeks prior to surgical date may result in cancellation of the procedure. Thank you.