

NEW YORK CENTER FOR PLASTIC SURGERY

Robert A. Guida M.D., F.A.C.S.

Height: _____ Weight: _____ Weight loss/gain the past year: _____ (lbs.)

When was your most recent check up? ____/____/____

Did it include: an EKG? Yes No A chest X-ray? Yes No

Current medications: (Please list ALL medications you are now taking and their dosages, including birth control pills, blood pressure, or heart medications, pain medications, or any other prescribed or over the counter medications, also any recreational ("street drugs")

Are you allergic to any medications: Yes No

If yes, (Please List):

To the best of your knowledge, do you have any of the following:

Latex Allergy/Sensitivity Food Allergy

Previous surgeries

(Please List):

Operation: _____ Year: _____ Hospital: _____

Doctor: _____ Local Anesthesia General Anesthesia

Operation: _____ Year: _____ Hospital: _____

Doctor: _____ Local Anesthesia General Anesthesia

Operation: _____ Year: _____ Hospital: _____

Doctor: _____ Local Anesthesia General Anesthesia

Operation: _____ Year: _____ Hospital: _____

Doctor: _____ Local Anesthesia General Anesthesia

Previous illnesses:

(Please List):

Are you currently suffering or being treated for any illness or conditions?

(Please List):

Do you smoke? Yes No Do you drink? Yes No If yes, how much _____

Please indicate if you have received information regarding the providers in this organization. This information can be found in your "welcome to our office" information packet. Yes No

For women only:

Are you pregnant? Yes No

Are you breastfeeding? Yes No

Authorization to release information:

I hereby authorize Dr. Robert A. Guida, M.D., F.A.C.S., P.C. to furnish information to my insurance carriers and to other physicians who may become involved in my care, concerning illness and treatments received by me.

Legal signature: _____ Date: ____/____/____

Medical History Form