

**WEST HOUSTON PLASTIC SURGERY CLINIC, P.A.**  
**PLASTIC RECONSTRUCTIVE AND AESTHETIC SURGERY**  
 915 Gessner Suite 825  
 Houston, Tx 77024  
 713-468-5200

All the following information is strictly confidential and necessary for your optimal care.

Patient's Name		Pharmacy phone number	
Reason for your appointment (please be specific)			
Referred by: Dr.		please circle: internet Other:	
Do you authorize Dr. to send a thank you letter to your referral source? YES / NO			
Are you allergic to any medication? If yes, please list:			
Are you allergic to Local Anesthetics? If yes, please list:			
Specifically, are you allergic to Penicillin? YES/ NO If so, what kind of reaction do you have?			
Do you have, or have you ever, had hayfever or asthma? YES / NO			
ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?			
Cortisone Drugs, Steroids or ACTH YES / NO			
Tranquilizers or Sedatives YES / NO			
Anticoagulants or Blood Thinners YES / NO			
List any currant medications/ vitamins:			
List all surgeries the patient has had under general anesthesia and any complications during surgeries:			
List any illness that has required hospitalization:			
Height		Weight	
BMI		Do you smoke? YES / NO	
		Do you Vape? YES / NO	
How many packs per day?			
Do you take weight loss medication or injections? YES / NO (Ozempic, Semaglutide, Mounjaro, Tirzepatide, Wegovy, Zepbound, etc)			
Do you drink any alcoholic beverages? YES / NO		How often?	
		How much?	
Have you had?	Please circle	Have you had?	Please circle
HEART TROUBLE	YES / NO	BLOOD DISEASE	YES / NO
HIGH BLOOD PRESSURE	YES / NO	PROLONGED BLEEDING	YES / NO
IRREGULAR HEART BEAT	YES / NO	SHORTNESS OF BREATH	YES / NO
FAINTING TENDENCIES	YES / NO	CHEST PAIN	YES / NO
DIABETES	YES / NO	ANEMIA	YES / NO
TUBERCULOSIS	YES / NO	FREQUENT THIRST	YES / NO
KIDNEY TROUBLE	YES / NO	PSYCHIATRIC TREATMENT	YES / NO
H.I.V ANTIBODY TEST	YES / NO	HEPATITIS	YES / NO
IF YES, RESULT?	POSITIVE / NEGATIVE	IF YES, WHICH TYPE?	A B C

SIGNATURE: \_\_\_\_\_

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