PREOPERATIVE EVALUATION

DE MILUS PLASTIC SURGERY

MARIO LACAYO, M.D

Date:

Name …….. Sex
Age:

Birth Date Marital Status: S M Dv
Occupation……

Street Address: ……..... City
State

e-mail…….....Cell
Ph….……Work Phone:

Emergency Phone:……Person responsible for Medical Fees:

Referred
by:…….

HABITS

Smoking Y N amount Coffee/Tea/Cola Y N amount

Alcohol Y N amount Other recreational drugs: Y N

Regular exercise: Y N type, frequency

MEDICATIONS

Prescription Meds (list,
dose)……
……

Non Prescription Meds (Vitamins,
Herbs)…….

Are you taking Aspirin or Anticoagulants? Y N For which
condition?.....

MEDICATION ALLERGIES No known allergies Allergic to Tape? Iodine?
Latex?

PLEASE ANSWER Y/N TO ALL OF THE FOLLOWING QUESTIONS

Asthma Y N recent Cold Y N Coughing Y N Pneumonia Y N Breathing difficulty Y N

High Blood pressure Y N Irregular heart beat Y N Heart Murmur Y N Chest Pain Y N

Heart Attack Y N EKG Y N when why Stress Test: Y N when

Kidney problems Y N UTI Y N Kidney Stones Y N

Heartburn Y N Gastritis/Ulcer Y N Jaundice Y N Fatty Liver Y N

Diabetes Y N Thyroid Y N Arthritis Y N

Anemia Y N Blood Transfusions Y N Bleeding problems Y N

Migraine Y N Fainting Y N Dizzy Spells Y N Seizures Y N

Back/Neck Pain Y N Depression Y N Sleep Apnea Y N

Are you pregnant? Y N # Pregnancies: Losses: Live births:

Other serious Illness: Last Medical Exam

PREVIOUS PLASTIC SURGERIES (list, dates, places)……
……

OTHER SURGERIES……
……

HAVE YOU HAD ANESTHESIA? Y N Which type? When?

General Spinal/Epidural

Any complications with Anesthesia with you or your family? Y N Please specify:

Today´s reason for consultation (which procedure(s) are you interested in?)

Please fill out evaluation and email it back at: drmlacayo@cablenet.com.ni