Dr. Anh Lee
PLASTIC SURGERY

3270 Joe Battle, Suite #360
El Paso, TX 79938
Phone: 915.351.9000 fax: 915.351.9041

Are you currently under a Physician's care? If yes, who? _____

Date of last physical exam: _____ Date of last Mammogram: _____ Have you ever had BRCA Testing: □ YES □ NO
Age started period: _____ Age started Menopause: _____ Age at first delivery: _____ Breast Feeding: □ YES □ NO
Number of Pregnancies: _____ Number of Miscarriages: _____

Please list all medications: (Please list strength) _____
_____
_____
_____
_____

Allergies : _____

Have you ever any significant problems with anesthesia? □ YES □ NO Explain: _____
_____

Are you pregnant or suspect you may be?	□ YES □ NO
Do you use any birth control medications? Name: _____	
Have you ever been treated for or been told you might have heart disease or a heart condition?	□ YES □ NO
Do you have high or low blood pressure? (Please circle one)	□ YES □ NO
Do you have a pacemaker or an artificial heart valve implant?	□ YES □ NO
Have you ever had rheumatic fever?	□ YES □ NO
Have you used ACUTANE? If yes, when? _____	□ YES □ NO
Have you ever taken the diet pill PHEN-FEN or PHENTERMINE?	□ YES □ NO
Have you ever had a serious illness? _____	□ YES □ NO
Have you ever had Plastic Surgery? _____	□ YES □ NO
Have you ever had Radiation Treatment, Chemotherapy? When: _____	□ YES □ NO
Do you have any blood disorders such as anemia, leukemia and/or immunodeficiency disorders?	□ YES □ NO
Have you ever bled excessively after being cut or injured?	□ YES □ NO
Do you have acid reflux, hiatal hernia, ulcers or difficulty swallowing? (Please circle one)	□ YES □ NO
Do you have any kidney or liver problems? (Please circle one)	□ YES □ NO
Do you have a history of sleep apnea?	□ YES □ NO
Are you HIV positive?	□ YES □ NO
Do you have or have you tested positive for Hepatitis?	□ YES □ NO
Do you have or have you had Tuberculosis?	□ YES □ NO
Do you smoke, chew, use snuff or any other forms of tobacco, including cigars?	□ YES □ NO
Would you accept blood in an emergency?	□ YES □ NO

Do you have any other condition or problem not listed? (Please list) _____

I certify that the above information is complete and accurate

PATIENT NAME: _____ DOB: _____ DATE: _____

Adopted: 10/15