AZUL
Cosmetic Surgery and Medical Spa
PATRICK M. FLAHARTY, M.D.

Patient Medical History Date: _____

Name: _____ Date of Birth: _____

Sex: □ Male □ Female Weight: _____ Height: _____ Race_____

Reason for Visit?:_____

HEALTH HISTORY - please check all that apply & write diagnosis date (approx.)

Cardiovascular:
- Heart Disease _____
- Angina
- High Blood Pressure
- Pacemaker/Defibrillator
- Angina
- Heart Murmur
- Atrial Fibrillation
- High Cholesterol
- Congestive HF

Musculoskeletal:
- Arthritis
- Joint Replacement

Endocrine:
- Diabetes
- Thyroid

Neurologic:
- Seizures/Convulsions
- Alzheimer's
- Parkinson's
- ADHD / ADD
- Narcolepsy
- Stroke _____

Respiratory:
- Lung Disease
- Chest
- Asthma
- Sleep Apnea
- COPD

Skin:
- Keloids/Scarring
- Herpes Simplex

GI and GU:
- Ulcers
- Colitis / Diverticulitis
- Liver / Hepatitis
- Kidney
- Bladder
- Prostate

Oncology:
- Cancer

Eye:
- Cataracts
- Glaucoma
- Diabetic Retinopathy
- Macular Degeneration
- Retinal Disorders
- Corneal Problems

Ear/Nose/Throat
- Hearing Loss
- Wear Hearing Aids

Hematologic:
- Anemia
- Bleed / Bruise Easily
- HIV
- Hepatitis B and/or C

Eye or Eyelid Surgery Dates:

Are you Diabetic? Yes No Are you Diet Controlled? Oral Medication Controlled Insulin Controlled

When were you first diagnosed? _____

Are you on blood thinners? Yes No _____

Do you take aspirin? Yes No _____

Have you ever had a cold sore? Yes No _____

Do you have any metal or implants in your body? Yes No – if Yes, detail: _____

Have you had an EKG in the past 6 months? Yes No – if Yes, where: _____

Do you smoke or use tobacco? Yes No – if Yes, how much per week? _____

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If don't currently smoke and have quit, please detail when:

Do you have any allergies? Yes No – if Yes, detail:

Past Medical History: Please list any surgery, injuries, operations, or hospitalizations other than eyes:

Who is your Primary Care Doctor?

Patient Medication History

Patient's Name: _____

Who is your Primary Care Doctor? _____

Are you allergic to any medications? ☐Yes ☐No, if Yes please list below:

_____

_____

Are you allergic to IODINE? ☐Yes ☐No
Do you need Pre-op antibiotics? ☐Yes ☐No

Please list all medications that you are currently taking including eye drops and vitamins		
MEDICATION	**STRENGTH**	**HOW OFTEN**

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Patient Signature: _____