BASSIN CENTER

FOR PLASTIC SURGERY

Dr. Roger Bassin

Patient Name: ________________ Reason for Consult: ______________________

Date of Birth: __________________ Today's Date: ____________________________

Past Medical History

Digestive Problem	Yes	No	Neurological Problems	Yes	No
Ulcers	Yes	No	Seizures or Epilepsy	Yes	No
Heart Attacks	Yes	No	Urological Problems	Yes	No
Angina	Yes	No	Incontinence	Yes	No
CHF (heart failure)	Yes	No	Enlarged Prostate	Yes	No
Heart Arrythmias	Yes	No	Cancer/Tumors	Yes	No
Stroke/CVA	Yes	No	Asthma	Yes	No
Mini-stroke / TIA	Yes	No	Difficulty Breathing	Yes	No
Aneurysm	Yes	No	Pulmonary Problems	Yes	No
High Blood Pressure	Yes	No	Anxiety	Yes	No
Low Blood Pressure	Yes	No	Depression	Yes	No
High Cholesterol	Yes	No	Psychosis	Yes	No
Diabetes	Yes	No	Psychiatric Problems	Yes	No
Thyroid Problems	Yes	No	Blood Clots/Bleeding	Yes	No

If you circled yes to any of the above, please explain:

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Surgical History

Please list ALL surgeries that you have had. Also list the reason and date of these surgeries as well as if there were any complications (i.e. prolonged recovery time, scarring, infection, bleeding etc...)

Type of Surgery	Reason for Surgery	Date of Surgery	Complications
__________________	____________________	_____________	Yes No
__________________	____________________	_____________	Yes No
__________________	____________________	_____________	Yes No