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Medical Screening Form

Name: _____ Internist/GP: _____

DOB: _____ Age: _____ Referring Dr: _____

Height: _____ Weight: _____ Pharmacy #: _____

Reason for Consultation: _____

Have You / Do You...

- Spoken with another dermatologist/plastic surgeon regarding your concern? YES NO
- Experience excess bleeding following surgery or dental procedures? YES NO
- Had any complications from surgery, dental work? (difficult to numb, etc.) YES NO
- Any history of Motion Sickness? YES NO
- Have any significant emotional disorder?
Or been emotionally upset recently? YES NO
- Had any prior plastic surgery? If YES, by whom? _____ YES NO
***Had Lipo Dissolve or Mesotherapy? YES NO
- Do you SMOKE? Or use Nicotine substitutes or tobacco in any form? YES NO
If YES, how much? _____
- Are you pregnant OR planning to become pregnant soon? YES NO
- Have you or a family member ever had skin cancer? If YES, what type? _____ YES NO

Allergic/Bad

Reaction To:

- Y N**
- Anesthesia
 - Antibiotics
 - Codeine
 - Demerol
 - Adhesive Tape
 - Latex
 - Aspirin
 - Sulfa
 - Penicillin
 - Local Anesthetics
 - Iodine
 - Morphine
 - Egg Allergy
 - Other

Do You Take:

- Y N**
- Blood Pressure Medication
 - Heart Medication
 - Diet Pills
 - Diuretics (water pills)
 - Vitamins/Supplements
 - Tranquilizers
 - Alcohol
 - Sleeping Pills
 - Pain Meds
 - Accutane
 - Hormone Replacement
 - Aspirin/Anit-Inflammatory
 - Blood Thinning Medications

Do You OR Have You Had:

- Y N**
- Cancer (other than skin)
 - Radiation/Chemotherapy
 - Shortness of Breath
 - Mitral Valve Prolapse
 - Heart Attack
 - Irregular Heart Beat
 - Asthma/Breathing Disorders
 - Bronchitis
 - TB
 - Blood Clots
 - Headaches
 - Drug Abuse
 - Alcoholism
 - Seizures
 - Depression
 - Bruise Easily
 - Cold Sores
 - Artificial Joints or Implantable Devices

- Y N**
- Pacemaker/Defibrillator
 - Dry Eyes
 - Vision Problems
 - Diabetes
 - Lung Disease
 - High Blood Pressure
 - Coronary Artery Disease
 - Hepatitis
 - Lupus
 - Scleroderma
 - Melanoma
 - Thyroid Disease
 - Arthritis
 - Lyme Disease
 - HIV/AIDS
 - Keloid Scarring
 - Nose Bleeds
 - Permanent Make-Up

Please complete BOTH SIDES of this form!