

**Carlos E. Spera M.D.**  
*Plastic and Reconstructive Surgery*

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Hialeah, FL 33012  
(305) 698-0070

**Flagler Park Plaza**  
8227 West Flagler Street  
Miami, FL 33144  
(305) 267-6777

**HEALTH HISTORY**

THIS FORM MUST BE COMPLETED AND SIGNED

GENERAL HEALTH: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_

MEDICATIONS: (Prescription and over the counter: vitamins, herbal medications. Please include mg and dosage.)

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ALLERGIES: \_\_\_\_\_

SURGERIES/DATES: \_\_\_\_\_

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HAVE A HISTORY OF?

\_\_\_ HEART DISEASE                      \_\_\_ MENTAL DISEASE                      \_\_\_ NEURO-MUSCULAR DISEASE  
\_\_\_ EXCESSIVE BLEEDING                      \_\_\_ AUTO-IMMUNE DISORDERS                      \_\_\_ DIABETES  
\_\_\_ HIGH BLOOD PRESSURE                      \_\_\_ LIVER DISEASE                      \_\_\_ COLD SORES/FEVER BLISTERS  
\_\_\_ OTHER

ARE YOU? PREGNANT \_\_\_\_\_ NURSING \_\_\_\_\_

DO YOU? SMOKE \_\_\_\_\_ DRINK ALCOHOL \_\_\_\_\_ AMOUNT PER DAY \_\_\_\_\_

DO YOU TAKE ASPIRIN OR SIMILAR MEDICATIONS? \_\_\_\_\_ IF YES, HOW MUCH \_\_\_\_\_

DO YOU TAKE VITAMIN E? \_\_\_\_\_ IF YES, HOW MUCH \_\_\_\_\_

***THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.***

\_\_\_\_\_  
**PATIENT NAME** (print)

\_\_\_\_\_  
**PATIENT SIGNATURE** (or legal representative)

\_\_\_\_\_  
**DATE**