



DAVID C. MABRIE, M.D.  
BOARD-CERTIFIED FACIAL COSMETIC SURGEON

SAN FRANCISCO UNION SQUARE  
166 GEARY STREET, SUITE 1502  
415.445.9513

EAST BAY PINOLE  
1700 SAN PABLO AVENUE, SUITE F  
510.724.6662

www.yourfaceinourhands.com

### Medical History

Name

\_\_\_\_\_  
First Last Middle

Medical

<i>Do you have or had:</i>	Yes	No		Yes	No
Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Vision Deficits	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other, if so describe		<input type="checkbox"/>

Surgical

Previous Operations:

Medications

Name	Dosage (if known)	Name	Dosage (if known)
_____	_____	_____	_____
_____	_____	_____	_____

*Do you or have you taken:* Yes No

Aspirin or Ibuprofen   Accutane? \_\_\_\_\_ Date \_\_\_\_\_

Coumadin (Warfarin)   Tretinoin? \_\_\_\_\_ % \_\_\_\_\_

Steroids in the past year

Allergies

None If Yes, please list: \_\_\_\_\_

Scarring/  
Other

Have you formed excessive or unsatisfactory scars in the past?  Yes  No

Do you have herpes simplex? (fever blisters) \_\_\_\_\_

Birth Control Pills? \_\_\_\_\_ Currently Pregnant? \_\_\_\_\_

Breast Feeding \_\_\_\_\_ Attempting Pregnancy? \_\_\_\_\_

Personal  
Physician

Name of regular physician: \_\_\_\_\_ Specialty: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

Business Telephone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Family History

*Is there a history of the following in your immediate family? If so, please list the family member beside the disease.*

	No	Yes	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Family member: _____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Family member: _____
Anesthesia Reaction	<input type="checkbox"/>	<input type="checkbox"/>	Family member: _____

Personal History

Do you smoke?:  No  Yes, \_\_\_\_\_ pack(s) per day.