CENTRE *for* PLASTIC SURGERY

PATIENT HEALTH HISTORY

PATIENT INFORMATION

Name:				Today's date:
First	Middle Initial	Last		
Sex:	Date of birth:	Age:	Height:	Current Weight:
Primary Care Physician:				
Name	City	Phone Number		
Preferred Pharmacy:				
Name	City	Phone Number		
What are you seeing the doctor for today?				
Have you seen another plastic surgeon for the same concern that brings you in today?	Yes	No		
Are you being seen as the result of an injury or accident?	Yes	No	Date of accident:	

MEDICATIONS

Please list all medications you are currently taking regularly including strength/dosage and frequency. Please be sure to include birth control, over-the-counter medications, multi-vitamins, diet pills and homeopathic/natural supplements. Especially important are Vitamin E, St. John's Wort, Aspirin, Ibuprofen, Aleve, Advil, Excedrin, Phentermine (Adipex-P) and Fenfluramine/Phentermine (FEN-PHEN).

Medication	Strength/Dose	Frequency	Medication	Strength/Dose	Frequency

ALLERGIES & SENSITIVITIES

Please list all allergies or sensitivities (including medications, foods and environmental/seasonal) and your reaction to these things. Please be sure to include allergies or sensitivities to latex/rubber, adhesive and contrast dye.

☐ *NO KNOWN ALLERGIES OR SENSITIVITIES*

Allergy/Sensitivity To:	Reaction	Allergy/Sensitivity To:	Reaction

PREVIOUS SURGERIES & HOSPITALIZATIONS

Please list all previous surgeries and hospitalizations including approximate year and hospital/facility. Please be sure to include any cosmetic procedures and wisdom teeth extraction.

Surgery or Reason Hospitalized	Approximate Year	Hospital or Facility	Surgery or Reason Hospitalized	Approximate Year	Hospital or Facility

SOCIAL HISTORY

Have you ever smoked or used tobacco/nicotine products?	Never	Currently	Formerly
If yes, how much? */day*	How long? *years*	When did you quit?	
Do you drink alcohol?	No	Yes	How much?
Do you use recreational drugs?	No	Yes	If yes, what? How much?

Physician Notes:

Pre-Op Concerns:

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FAMILY HISTORY

Please list all known medical problems and illnesses for the following blood relatives. Be sure to include diabetes, stroke, heart disease, cancer, high blood pressure and bleeding disorders.

Family Member	Medical Problems/Illnesses		
Father:			
Mother:			
Siblings:			
Your Children:			
Have you or anyone in your family ever had unusual reactions to anesthesia (such as muscle weakness, jaundice, breathing problems or unexpected fevers)?		Yes	No

TREATING SPECIALTY PHYSICIANS

Please list any physicians (other than your primary care physician) you see for medical problems or illnesses (including but not limited to cardiologists, endocrinologists, psychiatrists/psychologists, neurologists, hematologists, dermatologists and gynecologists). Be sure to include the city they practice in, their phone number and approximate date of last exam.

Physician Name	City	Phone Number	Last Exam

REVIEW OF SYSTEMS

Please check all of the following medical conditions you now have or have had in the past. If you are unsure, place a question mark (?) in the box.

General

	Weight loss greater than 10 lbs. in the last year.
	Fever
	Trouble Sleeping
	Poor Appetite
	Prior Trauma

Eyes

	Glasses/Contacts
	Loss or Change in Vision
	Glaucoma or Cataracts
	Dry Eyes
	Frequent Use of Eye Drops

Ear, Nose & Throat

	Trouble Breathing Through Nose
	Nose Bleeds
	Hearing Aids/Hearing Loss
	Recurrent Ear Infections
	Sore Throat/Strep Throat

Cardiovascular

	High Blood Pressure
	Heart Murmur
	Mitral Valve Prolapse
	Irregular Heartbeat
	Previous Heart Attack
	Chest Pain
	Deep Vein Thrombosis (DVT)
	History of Blood Clots/Bleeding

Respiratory

	Shortness of Breath
	Asthma
	History of Tuberculosis (TB)
	Chronic Cough
	Emphysema
	COPD (Chronic Obstructive Pulmonary Disease)
	History of Apnea/Use CPAP
	Pulmonary Embolism (PE)

Gastrointestinal

	Ulcers
	History of Jaundice or Cirrhosis
	Heart Burn/Reflux/GERD
	Hernia
	Hepatitis (Type:)

Genitourinary

	Problems Urinating (Incontinence, Burning, Frequency)
	Bladder Infections

Skin

	Skin Cancer Where? ____________________ What Type? ________________
	Problems with Scarring Describe: __________________ __________________________
	Ever Used Accutane When? ____________________
	Bruise Easily

Neurologic

	Blackouts/Fainting/Confusion
	Seizures/Stroke

Psychiatric

	History of Severe Depression
	Prior Counseling/Inpatient Treatment
	Alcoholism
	Other:

Endocrine

	Diabetes
	Thyroid Problems

Immunologic

	HIV/AIDS
	Autoimmune Disorders
	MRSA

Hematologic/Lymphatic

	Bleeding Disorders
	Enlarged Lymph Nodes

Females Only

	Breast Lumps
	Bloody Nipple Discharge
	Abnormal Mammogram
	Prior Breast Biopsy
	History of Breast Cancer – Self or Family
Date of Last Mammogram: ________ Location:	
Number of Pregnancies	
Number of Children	
Currently Nursing?	
Do You Plan to Have More Children?	

I certify that I have disclosed my complete medical history to the best of my knowledge.

Patient's Signature: ____ Date: ______________

Physician's Signature: ____ Date: ______________