PLASTIC SURGERY SPECIALISTS
MEDICAL HISTORY FORM

Date____________________ Name______________________________________ Birthdate_____________ Sex □M □F

Referring Physician____________________________ Primary Care Physician_________________________________

Reason for today's visit: ____

PAST MEDICAL HISTORY Have you ever had any of the following:

Skin cancer	□ Y □ N	Are you on blood thinners	□ Y □ N	Asthma	□ Y □ N
Breast cancer	□ Y □ N	Pulmonary embolism	□ Y □ N	Emphysema	□ Y □ N
Cleft lip/palate	□ Y □ N	Deep vein thrombosis (DVT)	□ Y □ N	Bronchitis	□ Y □ N
Are you pregnant	□ Y □ N	EKG	□ Y □ N	Tuberculosis	□ Y □ N
Cataracts	□ Y □ N	Peripheral vascular disease	□ Y □ N	Pneumonia	□ Y □ N
Permanent vision loss	□ Y □ N	Echocardiogram	□ Y □ N	GERD	□ Y □ N
Glaucoma	□ Y □ N	Heart attack	□ Y □ N	Diverticular disease	□ Y □ N
Dental extraction	□ Y □ N	Heart failure	□ Y □ N	Liver disease	□ Y □ N
Depression	□ Y □ N	Heart murmur	□ Y □ N	Pancreatitis	□ Y □ N
Diabetes	□ Y □ N	Artificial heart valve	□ Y □ N	Gout	□ Y □ N
Wound healing problems	□ Y □ N	Rheumatic fever	□ Y □ N	Osteoporosis	□ Y □ N
Thyroid disease	□ Y □ N	Stroke	□ Y □ N	Joint replacement	□ Y □ N
High cholesterol	□ Y □ N	Seizures / Epilepsy	□ Y □ N	HIV infection / AIDS	□ Y □ N
High blood pressure	□ Y □ N	Meningitis	□ Y □ N	Hepatitis	□ Y □ N
				if so what type?	__________

Other medical problems: Please list all not included in above checklist

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SURGICAL/HOSPITALIZATION HISTORY Please list any surgery or hospitalization you have had and when they took place.

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

MEDICATIONS/SUPPLEMENTS Please list all medications you are taking. Include over the counter medications and any herbal, nutritional, vitamin supplement or steroid. **(Please include dose & how often you take them.)**

PRESCRIPTION MEDICATION

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

OVER THE COUNTER MEDICATION **VITAMIN & NUTRITIONAL SUPPLEMENTS**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Patient Name___________________ DOS__________

ALLERGIES Please list any medication allergies that you have.

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Are you allergic to any of the following:

Latex	□ Y □ N	Vaccines	□ Y □ N	Milk	□ Y □ N
Lidocaine	□ Y □ N	Eggs	□ Y □ N	Adhesive tape	□ Y □ N
Bee Stings	□ Y □ N	Peanuts	□ Y □ N	Other?_____________ _________	

FAMILY HISTORY Has any one in your family had a problem with the following:

Anesthesia	□ Y □ N	Clotting	□ Y □ N	Lung problems	□ Y □ N
Bleeding	□ Y □ N	Diabetes	□ Y □ N	Skin cancer	□ Y □ N
Breast cancer	□ Y □ N	Blood clots	□ Y □ N	Slow healing	□ Y □ N
Cleft lip/Palate	□ Y □ N	Heart problems	□ Y □ N	Stroke	□ Y □ N
				Other cancer	□ Y □ N

Explain:____

SOCIAL HISTORY

Drink Alcohol/Ethanol	□ Y □ N	If yes, how many drinks per week? Beer_____Wine_____Liquor____
Smoke tobacco	□ Y □ N	If yes, how many packs per day ______for how many years_____
Chew tobacco or snuff	□ Y □ N	
Street drugs	□ Y □ N	If yes, list.

DIETARY RESTRICTIONS

Vegetarian	□ Y □ N	Vegan	□ Y □ N
Limit protein	□ Y □ N	Other	

REVIEW OF SYSTEMS Do you have any of these symptoms?

GENERAL		**RESPIRATORY**		**SKIN**	
Weight change	□ Y □ N	Shortness of breath	□ Y □ N	Keloids	□ Y □ N
Fatigue/energy loss	□ Y □ N	Wheezing	□ Y □ N	Rash	□ Y □ N
Fevers	□ Y □ N	Cough	□ Y □ N	Itching	□ Y □ N
Heat or cold intolerance	□ Y □ N	**GASTROINTESTINAL**		Flushing	□ Y □ N
Night sweats	□ Y □ N	Abdominal pain	□ Y □ N	Scar Easily	□ Y □ N
Changes in nails	□ Y □ N	Heartburn or ulcers	□ Y □ N	Hair Loss	□ Y □ N
EYES		Loss of appetite	□ Y □ N	**NEUROLOGICAL**	
Blurry vision	□ Y □ N	Nausea or vomiting	□ Y □ N	Headaches or migraines	□ Y □ N
Blindness	□ Y □ N	Constipation	□ Y □ N	Dizziness	□ Y □ N
Dry Eyes	□ Y □ N	Diarrhea	□ Y □ N	Fainting	□ Y □ N
Light sensitivity	□ Y □ N	Blood in stools	□ Y □ N	Muscle weakness	□ Y □ N
Wear glasses	□ Y □ N	**GENITOURINARY**		Numbness	□ Y □ N
EAR/NOSE/THROAT		Loss of bladder control	□ Y □ N	Tingling	□ Y □ N
Sore throat	□ Y □ N	Frequent urination	□ Y □ N	**PSYCHIATRIC**	
Changes in voice	□ Y □ N	Painful urination	□ Y □ N	Panic disorder	□ Y □ N
Trouble swallowing	□ Y □ N	Blood in urine	□ Y □ N	Mood changes	□ Y □ N
Frequent runny nose	□ Y □ N	Menstrual problems	□ Y □ N	Depression	□ Y □ N
Hearing loss	□ Y □ N	**MUSCULOSKELETAL**		Anxiety/Nervousness	□ Y □ N
CARDIO/VASCULAR		Muscle pain	□ Y □ N	**HEMATOLOGICAL**	
Murmur	□ Y □ N	Arthritis or joint pain	□ Y □ N	Anemia	□ Y □ N
Chest pain	□ Y □ N	Back or neck pain	□ Y □ N	Bleed or bruise easily	□ Y □ N
Irregular heartbeat	□ Y □ N	Fibromyalgia	□ Y □ N	Blood clots	□ Y □ N
Swelling in feet	□ Y □ N			**IMMUNE**	
Dyspnea on exertion	□ Y □ N			Frequent infections	□ Y □ N
				Swollen glands	□ Y □ N

Height ________ Weight_________

Patient Signature ___________________ Reviewed by MD_______________________ Date _________