

PATIENT MEDICAL/SURGICAL HISTORY

What would you like to discuss with the doctor today? _____

In an effort to help us provide better care for you, please complete the following history (in black or blue ink).

Medical/Surgical History - Please check in the left column if you have or have had the following:

PAST MEDICAL HISTORY

Problem	Comments
Cardiovascular: (heart, blood vessels) <input type="checkbox"/> None	
<input type="checkbox"/> Chest Pain/Heart Attack	
<input type="checkbox"/> Palpitations ("skipping" heart beat; racing feeling)	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Mitral Valve Prolapse/Murmur	
<input type="checkbox"/> Open Heart Surgery/Angioplasty	
<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Blood Vessel surgery	
<input type="checkbox"/> Other <input type="checkbox"/> High Cholesterol	
Respiratory: (lungs, breathing) <input type="checkbox"/> None	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Tuberculosis (TB)	
<input type="checkbox"/> Shortness of Breath	
<input type="checkbox"/> Emphysema	
<input type="checkbox"/> Pneumonia/bronchitis	
<input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other:	
GI/Liver Disease: <input type="checkbox"/> None	
<input type="checkbox"/> Hepatitis <input type="checkbox"/> Jaundice	
<input type="checkbox"/> Cirrhosis <input type="checkbox"/> Reflux / GERD	
<input type="checkbox"/> Ulcer <input type="checkbox"/> Hernia	
<input type="checkbox"/> Gallbladder <input type="checkbox"/> Appendectomy	
<input type="checkbox"/> Other	
Cancer: <input type="checkbox"/> None	
<input type="checkbox"/> Location:	
<input type="checkbox"/> Treatment:	
Neuromuscular Disease: (nerve, muscles) <input type="checkbox"/> None	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Seizures or convulsions	
<input type="checkbox"/> Paralysis	
<input type="checkbox"/> Other	
Trauma (car accident, fall, etc.) <input type="checkbox"/> None	
Describe:	
What is your current Height: _____	
Weight: _____	

Problem	Nurse's Comments
Wound Healing Problems <input type="checkbox"/> None	
If yes, Describe:	
Endocrine: (glands) <input type="checkbox"/> None	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Other:	
Musculoskeletal: (muscles, bones, joints) <input type="checkbox"/> None	
<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Lupus	
<input type="checkbox"/> Bursitis	
<input type="checkbox"/> Fractures (broken bones)	
<input type="checkbox"/> Joint Replacement	
<input type="checkbox"/> Other:	
Ears, Nose, Throat: <input type="checkbox"/> Other: <input type="checkbox"/> None	
Describe:	
Genitourinary: (bladder, kidney) <input type="checkbox"/> None	
<input type="checkbox"/> Bladder Infection	
<input type="checkbox"/> Kidney Infection	
<input type="checkbox"/> Kidney Stones	
<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Other:	
Skin Disease: <input type="checkbox"/> None	
<input type="checkbox"/> Eczema	
<input type="checkbox"/> Dermatitis	
<input type="checkbox"/> Psoriasis <input type="checkbox"/> Other:	
Eye Disease: <input type="checkbox"/> None	
<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Cataracts <input type="checkbox"/> Other:	
Blood Disorder: <input type="checkbox"/> None	
<input type="checkbox"/> Sickle Cell <input type="checkbox"/> Trait	
<input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Disease	
<input type="checkbox"/> DVT'S <input type="checkbox"/> Other:	
Previous Psychiatric Treatment: <input type="checkbox"/> None	
Describe:	
Reproductive: <input type="checkbox"/> None	
<input type="checkbox"/> Breast Surgery Last Mammogram?	
<input type="checkbox"/> Hysterectomy Last Pap smear?	
<input type="checkbox"/> Pregnant # Children _____ Birth Control:	
<input type="checkbox"/> Testicular Disease/Surgery	
<input type="checkbox"/> Prostate Surgery Last prostate exam?	
<input type="checkbox"/> Sexual Transmitted Disease Type:	
<input type="checkbox"/> Other:	
<input type="checkbox"/> No Menstrual periods	

Previous Surgeries

Type	Year

Home Medications

Please list the medications (prescription, over-the-counter, diet pills, vitamins, or herbal) that you take at home.

Home Medications				
Medications	Dosage	Frequency	Last Dose (completed by nurse)	To Stop Taking Before Surgery
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Allergies: (Medications, food, tape, dyes, other)

No Known Allergies

Allergies	Type of Reaction

Patient Sticker

Latex Allergy/Sensitivity Screening:

- Do you have reactions to rubber products such as balloons, condoms, or gloves? No Yes
- Redness/swelling of his skin Swollen lips Itching Skin Rash
- Wheezing/breathing trouble Tearing of eyes/runny nose

ANESTHESIA HISTORY

Do you have:

- dentures/false teeth (upper, lower) capped/bonded teeth
- partial plate permanent bridge loose teeth
- location: _____

FAMILY HISTORY

Mother Alive Age _____ Deceased Age _____ Any Medical Problems _____

Father Alive Age _____ Deceased Age _____ Any Medical Problems _____

SOCIAL HISTORY (DO YOU USE THE FOLLOWING):

- Alcohol How much, how often? _____
- Tobacco how much, how often** _____
- Recreational/Street Drugs How much, how often? _____
- Married Single Divorced Separated
- Is your spouse or significant other supportive of you having plastic surgery:
- Yes No Don't Know Don't Care

Did you have any problems with your previous operations or anesthesia? No Yes

If yes, explain: _____

Have you or any of your blood relatives had a problem with anesthesia? No Yes

Have you ever had a blood transfusion? No Yes Describe: _____

REVIEW OF SYMPTOMS

Do you **CURRENTLY** have any of these symptoms: (Please mark all that apply) If none, check none.

Constitutional: Fever weight loss malaise none

Eyes: Change in vision blurred vision dry eye problems none

Ears, Nose, Mouth, Throat: Chronic infections of the throat, sinus or ears change in hearing none

Cardiovascular: Chest pain palpitations pains in legs from exertion none

Respiratory: Shortness of breath wheezing persistent cough blood tinged sputum none

Gastrointestinal: Stomach pain bloody stools black stools vomiting none

Genitourinary: Pain on urination blood in urine pus in urine none

Musculoskeletal: Pains in joints pains in muscles bony pain none

Integumentary (skin and/or breast): Rashes itching nipple discharge none

Neurological: Weakness paralysis tingling sensation numbness none

Psychiatric: Hallucinations uncontrolled fears mood swings depression none

Endocrine: Frequent urination dehydration change in weight change in activity none

Hematologic: Fatigue easy bruisability excessive bleeding bleeding gums none

Allergic/Immunologic: Reactions to any medications reaction to any substances none

Patient Sticker

Immunization History: Please check the vaccines you have had and the date of the last shot.

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Tetanus | Date: _____ | <input type="checkbox"/> Date Unknown |
| <input type="checkbox"/> Flu | Date: _____ | <input type="checkbox"/> Date Unknown |
| <input type="checkbox"/> Pneumonia Vaccine | Date: _____ | <input type="checkbox"/> Date Unknown |
| <input type="checkbox"/> TB Skin Test <input type="checkbox"/> Negative <input type="checkbox"/> Positive | Date: _____ | <input type="checkbox"/> Date Unknown |
| <input type="checkbox"/> Hepatitis Vaccine | Date: _____ | <input type="checkbox"/> Date Unknown |
| <input type="checkbox"/> Childhood immunizations received: | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | |

Children and Adolescents: N/A **Yes** **No** **If Yes, Explain**

- A. Special psychological needs _____
- B. Special developmental problems _____

Advance Directives (Living Will/Durable Power of Attorney for Healthcare):

Do you have a: Living Will Durable Power of Attorney for Healthcare? No Yes

If yes, would you like to provide a copy to place on your chart for this hospital visit? No Yes

copy placed on chart instructed patient/guardian to bring copy on day of surgery

If no, check your preference regarding additional information.... I do not want more information

I would like more information

Have you consulted with a plastic surgeon for this?

If yes, whom _____ Why did you not choose him/her? _____

Have you ever had plastic surgery? Yes _____ No _____

If yes, what type _____ By whom _____

Additional Comments: _____

How did you decide to make an appointment at our office?

How?

Specifically?

- | | |
|--|-------|
| <input type="checkbox"/> A doctor referred me | _____ |
| <input type="checkbox"/> A friend referred me | _____ |
| <input type="checkbox"/> Your practice is in my insurance book | _____ |
| <input type="checkbox"/> Advertising | _____ |
| <input type="checkbox"/> The emergency room referred me | _____ |
| <input type="checkbox"/> I saw your sign | _____ |
| <input type="checkbox"/> Other | _____ |

Signature: _____