PATIENT HISTORY

NAME: _____ **DATE:** _____

HEIGHT: _____ WEIGHT: _____ AGE: _____

Date of last physical: ____/____/____ Date of last mammogram: ____/____/____ Results: Normal or Abnormal

HAVE YOU OR DO YOU.... (please circle one)

1. Talked with other plastic surgeons about this problem? YES or NO
2. Have any bleeding after surgery or dental procedures? YES or NO
3. Had any complications from surgery, dental work, difficult to numb? YES or NO
4. Any history of Motion Sickness? YES or NO
5. Have any significant emotional disorder? Or been emotionally upset lately? YES or NO
6. ARE YOU PREGNANT OR PLANNING TO BECOME PREGNANT SOON? YES or NO
7. Any religious reason NOT to accept a blood transfusion? YES or NO

(CHECK ALL THAT APPLY)

Allergic or had bad reactions to:

___ Anesthesia
___ Antibiotics
___ Codeine
___ Demerol
___ Adhesive Tape
___ Latex
___ Aspirin
___ Sulpha
___ Penicillin
___ Local anesthetic
___ Iodine
___ Morphine
___ Others _____
_____

Do you take:

___ Blood Pressure medication
___ Heart medication
___ Diet Pills
___ Diuretics (water pills)
___ Vitamins
___ Tranquilizers
___ Alcohol
___ Sleeping Pills
___ Pain medication
___ Accutane
___ Hormone replacement
___ Anti-inflammatory drugs
___ Blood thinning medications
** Coumadin, aspirin, Plavix, et
___ Herbal supplements (Gingko, etc.

TOBACCO HISTORY: Cigarettes / Cigars / Chewing tobacco
NON – Smoker _____ Smoker _____ How much ? _____

LIST MEDICATIONS: _____
_____
_____
_____
_____

LIST ALL ADDITIONAL MEDICATION ON BACK

Do you have or have you had any of the following:

___ MRSA (Staph) culture of nose/MRSA infection

___ Cancer
___ Radiation therapy/Chemotherapy
___ Shortness of breath
___ Mitral Valve Prolapse
___ Heart attack
___ Arrhythmias (irregular heart beat)
___ Asthma or Breathing disorders
___ Bronchitis
___ TB
___ Blood clots in chest or legs
___ Lyme disease
___ Anemia
___ Headaches
___ Drug Abuse
___ Alcoholism
___ Seizures
___ Depression
___ Facial Paralysis
___ Psychiatric therapy
___ Dry eye (glaucoma, cataracts)
___ Vision problem (blindness one eye)
___ Thyroid disease
___ HIV
___ Diabetes
___ Bruise easily
___ Nose bleeds
___ Cold sores (fever blisters)
___ Keloid /hypertrophic scars
___ Hepatitis
___ Lupus
___ Scleroderma
___ Melanoma
___ Arthritis
___ AIDS

SURGICAL HISTORY : HAVE YOU HAD PRIOR PLASTIC SURGERY _____ By Whom ? _____

LIST ALL PREVIOUS COSMETIC AND MEDICAL SURGERY :

Procedure: _____ **Date:** _____ **Dr:** _____
Procedure: _____ **Date:** _____ **Dr:** _____
Procedure: _____ **Date:** _____ **Dr:** _____
Procedure: _____ **Date:** _____ **Dr:** _____
Procedure: _____ **Date:** _____ **Dr:** _____
Procedure: _____ **Date:** _____ **Dr:** _____