

# MEDICAL HISTORY

## IMPORTANT TO FILL OUT ACCURATELY & COMPLETELY

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Ethnic Background: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Bra Size (for breast surgery patients) \_\_\_\_\_

### MEDICAL HISTORY

	YES	NO
Do you smoke?..... How Much? _____ How Long? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcoholic beverages?..... How Much? _____ How Long? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you use street drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures, have loose or chipped teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to tape?.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to latex?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an allergy to Peanuts?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you or your family members had a problem with anesthesia?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hearing problems or wear a hearing aid?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses or contacts or have glaucoma?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you snore?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have sleep apnea?.....	<input type="checkbox"/>	<input type="checkbox"/>
Any chance that you are pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have heart problems (heart attack, chest pain, heart failure, irregular murmur)?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have lung problems (asthma, emphysema, or do you use nebulizers or inhalers)?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any stomach problems (ulcers, hernia)?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Diabetes?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Thyroid problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Circulation problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Bleeding Problems or are you taking Blood Thinners?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have HIV?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Cancer?..... Chemo? _____ Radiation? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you get frequent infections?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with motion sickness?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have emotional problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you under the care of a therapist, counselor, or psychiatrist?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any psychiatric or mental illnesses?.....	<input type="checkbox"/>	<input type="checkbox"/>

Do you get frequent Heartburn or Acid Reflux?.....

Have you seen other Plastic Surgeons for the same problem that brings you here today?.....

**DO YOU HAVE A PAST HISTORY OF:**

	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
Communicable Disease	<input type="checkbox"/>	<input type="checkbox"/>	Reproductive Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Bad Scarring	<input type="checkbox"/>	<input type="checkbox"/>	Serious Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Have you had Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>

**DO YOU HAVE A FAMILY HISTORY OF:**

	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	Anesthetic Problems	<input type="checkbox"/>	<input type="checkbox"/>
Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	Deep Vein Thrombosis/Embolicism	<input type="checkbox"/>	<input type="checkbox"/>

**CONTINUED MEDICAL HISTORY:**

Date of last physical exam: \_\_\_\_\_

Please list any illnesses you are being treated: \_\_\_\_\_

Please list any past serious Illnesses or Operations: \_\_\_\_\_

Please list any past serious Injuries: \_\_\_\_\_

Please list all medications you are taking: \_\_\_\_\_

Please list any allergies to medicines: \_\_\_\_\_