Patient History Form – Plastic & Reconstructive Surgery

Name:_____ Age: _____ Date: _____
Height:_____ Weight: _____
Primary Care Physician/Internist: _____ Telephone: _____
Cardiologist: _____ Telephone: _____

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY. IF YOU ARE NOT SURE OF A QUESTION, LEAVE IT BLANK.

What is the purpose for today's visit? _____
_____ FOLLOW.UP appointment for _____
_____ Routine exam (Skip questions 1 - 5)
_____ Problem (Answer questions 1 - 5)

1. Have you consulted other doctors about this problem? ☐Yes ☐No If yes please list_____
_____

2. Have you had any previous surgery for this problem? ☐Yes ☐No If yes please list _____
_____

Past Medical History: (Check all that apply)

□ High Blood Pressure	□ Liver Disease	□ Psychiatric Diagnosis
□ Heart Disease	□ Hepatitis	□ Depression or Anxiety (circle one)
□ Heart Failure	□ Stomach Problems	□ Eating disorder
□ Heart Attack	□ Gastric Reflux	□ Herpes
□ Heart Bypass Surgery	□ Gastric Bypass	□ HIV/AIDS
□ Chest Pain	□ Bleeding Problems/Easy bruising	□ Tuberculosis
□ Abnormal EKG	□ Blood clots	□ Cancer
□ Pneumonia	□ Sickle cell trait/Sickle cell anemia	□ Problems with anesthesia
□ Emphysema/COPD	□ Hypothyroid	□ Malignant hyperthermia (MH)
□ Asthma	□ Seizures	□ Other _____
□ Diabetes	□ Stroke	□ Other _____
□ Kidney Disease	□ Epilepsy	□ Other _____

Please list all prior Operations:	Date	Complications

Please list all prior Hospitalizations:

Medications: Please list ALL medications and/or dietary supplements including:
(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____

Allergies:
Do you have any Allergies to any medications? *(Please list including reactions)*

_____
_____
_____

Are you allergic to LATEX? ☐Yes ☐No Reaction_____

Do you have any other Allergies (i.e. Shellfish, eggs, etc)? *(Please list including reactions)*

_____

Social History:

Marital status? ☐ Single ☐ Domestic Partner ☐ Married ☐ Divorced ☐ Widowed

Have you ever smoked tobacco products? ☐Yes ☐No
If Yes # of packs per day? _____ # of years? _____
If you quit when? _____

Do you drink alcohol? ☐Yes ☐No If Yes average # of drinks per week? _____

Do you use anyone else's prescription drugs or other drugs not prescribed by a physician? ☐Yes ☐No
If Yes what? _____

Have you taken Steroids within the last year? ☐Yes ☐No If Yes, Medication Name:_____

Family History:

Does anyone in your family have a history of breast cancer? ☐Yes ☐No If yes who? _____

Has anyone in your family had complications from anesthesia? ☐Yes ☐No
Do you have any other family history of medical problems (list problem and family member)?

_____

Tell us how YOU have been feeling lately:

General
☐ Fever/ Chills
☐ Unplanned weight-loss

Eyes/Ears/Nose/Throat
☐ Vision Problem
☐ Eye Pain
☐ Dry Eyes
☐ Nose Bleeds
☐ Hearing Trouble
☐ Throat Discomfort
☐ Swollen lymph nodes

Heart
☐ Chest Pain/Pressure
☐ High Blood Pressure
☐ Heart Skipping/Irregular Heart beat
☐ Sudden fainting
☐ Shortness of breath lying down
☐ Swollen Feet or Ankles

Lungs
☐ Shortness of Breath
☐ Cough
☐ Sputum (Phlegm)
☐ Bloody Sputum (Bloody Phlegm)
☐ Wheezing

Abdomen
☐ Abdominal Pain
☐ Nausea/V omitting
☐ Constipation
☐ Diarrhea
☐ Black Stools
☐ Rectal Bleeding
☐ Acid Indigestion/Heartburn
☐ Jaundice (Yellow skin/eyes)

Urinary
☐ Night time Urine
☐ Increased Urine
☐ Difficulty with Urine flow (poor flow)
☐ Blood in Urine
☐ Burning with Urination

Hematology (Blood)
☐ Easy bruising
☐ Easy bleeding
☐ Blood clots

Endocrine (Hormones)
☐ Increased Thirst
☐ Heat Intolerance
☐ Dry skin
☐ Excess sweating

☐ Tremor
☐ Fatigue

Gynecological
☐ Irregular periods
☐ Pregnant
☐ Nipple discharge

Breast
☐ Breast pain
☐ Breast lump
☐ Nipple discharge

Musculoskeletal (Muscles and joints)
☐ Arthritis
☐ Muscle weakness
☐ Joint pain
☐ Joint swelling
☐ Backache

Skin
☐ Rashes

Neurological
☐ Numbness
☐ Balance problems
☐ Dizziness

Psychological
☐ Depression/Anxiety