

MEDICAL AND SURGICAL HISTORY

Name: _____

Occupation: _____ Age: _____ Height: _____ Weight: _____ # of Children: _____

Current Physician: _____ Referring Physician: _____

Medical Allergies: _____

Please Check One: Right handed _____ Left handed _____ Ambidextrous _____

*Please list all medications you are currently taking including vitamins, birth control pills, aspirin, diet pills, herbal supplements, and any health food store over the counter supplements:

Name	Dosage	Frequency

*Please list all medical problems, operations, and illnesses you have had including plastic surgery:

Medical problem, illness, operation, plastic surgery	Date	Comments

REVIEW OF SYSTEMS: Check any you now have or have recently had. Otherwise, check *Negative History*.

<p>Constitutional</p> <input type="checkbox"/> Pain <input type="checkbox"/> Weakness/Fatigue <input type="checkbox"/> Fever/Chills <input type="checkbox"/> Weight loss <input type="checkbox"/> <i>Negative History</i>	<p>Pulmonary</p> <input type="checkbox"/> Asthma/wheezing <input type="checkbox"/> Bronchitis <input type="checkbox"/> Tobacco use <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sleep apnea <input type="checkbox"/> <i>Negative History</i>	<p>Neurological</p> <input type="checkbox"/> Loss of facial expression <input type="checkbox"/> Weak grip <input type="checkbox"/> Paralysis <input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy <input type="checkbox"/> Head/Spinal injury <input type="checkbox"/> Myasthenia gravis <input type="checkbox"/> Mental illness <input type="checkbox"/> Seizures <input type="checkbox"/> Tingling/Burning/Numbness <input type="checkbox"/> Depression <input type="checkbox"/> <i>Negative History</i>	<p>Abdomen</p> <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> History GI problems <input type="checkbox"/> Hernias <input type="checkbox"/> Liver disease/Jaundice <input type="checkbox"/> Renal/Kidney disorder or infection <input type="checkbox"/> Heartburn/reflux <input type="checkbox"/> Currently pregnant <input type="checkbox"/> LMP <input type="checkbox"/> <i>Negative History</i>	<p>Surgical Complications</p> <input type="checkbox"/> Wound complications <input type="checkbox"/> Bleeding complications <input type="checkbox"/> Post op swelling of limbs <input type="checkbox"/> Anesthesia complications <input type="checkbox"/> Post op shortness of breath <input type="checkbox"/> Post op fevers <input type="checkbox"/> Difficulty voiding <input type="checkbox"/> History of post op vomiting/nausea <input type="checkbox"/> <i>Negative History</i>	<p>Breast</p> <input type="checkbox"/> Breast deformity <input type="checkbox"/> Small breasts <input type="checkbox"/> Normal breast size <input type="checkbox"/> Breast skin changes <input type="checkbox"/> Breast masses <input type="checkbox"/> Back pain from large breasts <input type="checkbox"/> Shoulder grooves from bra straps <input type="checkbox"/> Neck pain from large breasts <input type="checkbox"/> Breast pain <input type="checkbox"/> Personal/Family history of breast cancer <input type="checkbox"/> <i>Negative History</i>
<p>Cardiovascular</p> <input type="checkbox"/> MI/Heart attack <input type="checkbox"/> Cardiovascular disease <input type="checkbox"/> Coronary or peripheral artery disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Abnormal EKG <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> Blood clots in legs/lungs <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Aneurysm <input type="checkbox"/> Rheumatoid fever <input type="checkbox"/> <i>Negative History</i>	<p>Extremities</p> <input type="checkbox"/> Hand infection <input type="checkbox"/> Hand injury <input type="checkbox"/> Muscle or joint problem <input type="checkbox"/> Leg swelling <input type="checkbox"/> Swollen/Red joint <input type="checkbox"/> Hand pain <input type="checkbox"/> Hand numbness <input type="checkbox"/> Hand weakness <input type="checkbox"/> Waking up from hand pain/numbness <input type="checkbox"/> <i>Negative History</i>	<p>EENT</p> <input type="checkbox"/> Nasal deformity <input type="checkbox"/> Facial fractures <input type="checkbox"/> Dry eyes <input type="checkbox"/> Nasal obstructions <input type="checkbox"/> Double vision <input type="checkbox"/> Recent head trauma <input type="checkbox"/> Problem w/proper fitting of teeth <input type="checkbox"/> <i>Negative History</i>	<p>Skin</p> <input type="checkbox"/> Abscess <input type="checkbox"/> Wound <input type="checkbox"/> Burns <input type="checkbox"/> MOHs excision <input type="checkbox"/> Human bite <input type="checkbox"/> Animal bite <input type="checkbox"/> Varicose veins <input type="checkbox"/> Laceration <input type="checkbox"/> Suspicious lesions/moles <input type="checkbox"/> Skin cancers <input type="checkbox"/> Skin color changes <input type="checkbox"/> Tendency to sunburn <input type="checkbox"/> <i>Negative History</i>		
<p>Endocrine</p> <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> <i>Negative History</i>	<p>Hematological</p> <input type="checkbox"/> Blood disorder <input type="checkbox"/> Spontaneous or prolonged bleeding <input type="checkbox"/> Aids/HIV <input type="checkbox"/> Hepatitis <input type="checkbox"/> <i>Negative History</i>				

Physical Work: ___omit ___light ___moderate ___heavy Hours per day:_____

Exercise: ___omit ___light ___moderate ___heavy Hours per day:_____

Aspirin: ___none ___yes Qty/day:_____ How many years_____ Other: _____

Alcohol: ___never ___beers/wk ___liquor/wk ___wine/wk How many years_____

Tobacco: ___never ___discontinued ___current Type:_____ Qty:_____ How many years_____

Caffeine: ___none ___yes Cups/day:_____ How many years_____ Other: _____

Have you ever used: ___LSD ___Speed ___Cocaine ___Marijuana ___None

Have you or anyone in your family ever had problems with anesthesia: ___no ___yes Who?_____

If so, what happened:_____

Please Describe What Brings you Here

Cosmetic Consultation for: _____

Reconstructive Consultation for: _____

Follow Up:_____

Follow Up Surgery: _____

Other: _____

Chief Complaint

Date Symptoms began: _____

Frequency of Symptoms:_____

Symptoms are ___constant ___Intermittent ___occasional ___rare ___recurrent

Intensity of Symptoms: ___mild ___moderate ___severe ___excruciating

Duration:_____ **Location:**_____

Type of Pain: ___None ___Aching ___Burning ___Continuous ___Cramping ___Deep ___Delayed ___Dull

___Gnawing ___Gradual ___Intermittent ___Periodic ___Sharp ___Shifting ___Stabbing ___Sudden ___Superficial

Other:_____

How did symptoms start:_____

How did symptoms progress:_____

What brings it on:_____

What make it worse:_____

What Relieves it:_____

Associated symptoms:_____

Pain radiates to:_____

Antibiotic usage: _____

Comments:_____

For Patients Interested in Breast Surgery

Bra Size:_____ **Desired Bra Size:**_____

Date of Last Mammogram:_____ **Normal** ___ **Abnormal**___

Patient Signature:_____ **Date:**_____