PLASTIC SURGERY SERVICES **MEDICAL HISTORY SHEET**

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BOARD CERTIFIED PLASTIC SURGEON
PLASTIC SURGERY SERVICES

Name: _____ **Date:** _____ **Birth Date:** _____ **Age:** _____

Weight: _____lbs **Ht:** _____ **Preferred Pharmacy:** _____ **Street Name:** _____

Staff Notes: _____ **Phone Number of Pharmacy:** _____

What brings you to our office?

PAST MEDICAL HISTORY: Please check all applicable boxes & complete detail

- □ Anemia-Blood transfusions? _____
- □ Anxiety
- □ Asthma
- □ Atrial Fibrillation (Irregular heartbeat)
- □ Auto-Immune Disease
- □ Bipolar Disorder
- □ Blood Clotting Disorder/Bleeding Disorder
- □ Breast Cancer- When _____
- □ COPD
- □ Cancer-type: _____
- □ Coronary Artery Disease
- □ Deep Venous Thrombosis (Blood clot)
- □ Depression
- □ Diabetes- Oral Meds or Insulin
- □ GERD (acid reflux)
- □ Hepatitis
- □ Hypertension (high blood pressure)
- □ HIV/AIDS
- □ High Cholesterol
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Lupus
- □ Malignant Hypertension (high fever w/anesthesia)
- □ Health Hospitalization
- □ Neuromuscular Disorder - _____
- □ Pulmonary Embolism (blood clot in lung)
- □ Chemo or Radiation- When?_____
- □ Seizures
- □ Severe Reaction to Anesthesia
- □ Stroke
- □ Trauma
- □ Valvular Heart Disease
- □ Vision Loss
- □ None
- □ Other: _____

Past Surgeries: Please check all applicable boxes

- □ Hernia
- □ Appendectomy
- □ Mastectomy- Side: _____
- □ Lumpectomy-Side: _____
- □ Breast Biopsy- Side: _____ Result_____
- □ Cesarean Section
- □ Gallbladder
- ☐ CABG
- ☐ Heart Valve Replacement
- ☐ Joint Replacement
- ☐ Cardiac Stent Placed
- ☐ Skin Cancer removal: Basal, Squamous,
- ☐ Melanoma
- ☐ Hysterectomy

Gynecologic History

Last Mammogram: _____ Normal? ☐ Yes ☐ No: _____

Skin Disease History: Have you had any of the following skin conditions

☐ Acne ☐ Melanoma ☐ Eczema

☐ Actinic Keratosis (pre-cancer) ☐ Psoriasis ☐ None
☐ Basal Cell Skin Cancer ☐ Squamous Cell Carcinoma ☐ Other

Family History: Do you have a family history of Melanoma? ☐ Yes ☐ No If yes, which relative?

_____

STAFF ONLY

Plastic Surgery History: Please check all applicable boxes & note date if known

□ Abdominoplasty
□ Liposuction
□ CoolSculpting
□ Breast Augmentation
□ Breast Lift (Mastopexy)
☐ Breast Reduction
☐ Blepharoplasty
☐ Facelift
☐ NONE
☐ Other: _____

Breast Cancer: Do you have a family history of breast cancer? ☐ Yes ☐ No If yes, which relative?

_____

Malignant Hyperthermia and Anesthesia Sensitivity: Do you have a family history of MH or severe reactions to anesthesia?

☐ Yes ☐ No If so, which relative? _____ Reaction?

_____

Herbal Medications and Supplements: Do you take any herbal medications or supplements? ☐ Yes ☐ No

If yes, which do you take?

☐ Echinacea
☐ Fish Oil
☐ Gingko Biloba
☐ Phentermine
☐ St. John's Wort
☐ Vitamin A
☐ Vitamin B
☐ Vitamin C
☐ Vitamin D
☐ Vitamin E

Medications: Please list ALL current Medications and dose (if known) If you have a list, our receptionist can make a copy!

_____

_____

_____

_____

Allergies: List all allergies AND REACTIONS if known ☐ **No Known Drug Allergies**

_____

_____

_____

Social History:

☐ Current everyday smoker: Started smoking: _____ Number of packs/day_____ Quit:_____
☐ Current someday smoker
☐ Former smoker
☐ Never smoker

Alcohol Intake: ☐ None ☐ Social ☐ Daily

IV Drug Use: ☐ Yes ☐ No

Have you ever had the Pneumonia Vaccine? ☐ Yes, if so when? _____ ☐ No