# Center for Plastic Surgery

# Patient Medical History

**Name:** ______________________________ **Date:** ____________

**Height:** ________ **Weight:** ________ **Weight changes in the last year?** *Gain / Loss* __________ lbs

**Date of last physical:** ____________ **Name of physician:** ______________________

**Did it include an EKG?** *Yes / No* **Date of last mammogram:** ______________________

**ANY KNOW DRUG ALLERGIES:**

______________________________________________________________

**List ALL serious illnesses:**

______________________________________________________________

______________________________________________________________

**List ALL previous surgeries:**

*PROCEDURE* *YEAR* *SURGEONS NAME*

______________________________________________________________

______________________________________________________________

Have you ever seen or been referred to a Psychologist / Psychiatrist? ***Yes / No***
*If yes please explain:*

______________________________________________________________

______________________________________________________________

**SPECIFY DAILY USE:**

Tobacco: ______________________ Alcohol: ______________________

Recreational street drugs: ______________________________________

Are you a recovering alcoholic or drug user? ***Yes / No*** For how long? ______________________

List any and all medications you take on a regular basis *(please include homeopathic remedies, Aspirin containing products (Advil, Ibuprofen and Motrin) birth control products or estrogen:*

______________________________________________________________

______________________________________________________________

| **CHECK YES OR NO:** | **YES** | **NO** |
|---|---|---|
| Have you ever reacted badly to anesthesia before or during anesthesia? | ☐ | ☐ |
| Have family members reacted badly to anesthesia? | ☐ | ☐ |
| Have you ever reacted badly to "local" anesthesia? | ☐ | ☐ |
| Are you allergic to suture material such as Cat Gut? | ☐ | ☐ |
| Do you bleed easily from simple cuts? | ☐ | ☐ |
| Do you bruise easily? | ☐ | ☐ |
| Do you consider yourself a slow healer? | ☐ | ☐ |

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| | YES | NO |
|---|---|---|
| Do you have large or keloid scars? | ☐ | ☐ |
| Do you have a history of cold sores? | ☐ | ☐ |
| Do you have a history of frequent infections or boils? | ☐ | ☐ |
| Have you ever taken steroids, Cortisone or ACTH? | ☐ | ☐ |
| Do you experience shortness of breath when walking? | ☐ | ☐ |
| Does your religion prohibit a blood transfusion? | ☐ | ☐ |

**HAVE YOU EVER HAD ANY OF THE FOLLOWING ILLNESSES OR DISORDOR – PLEASE CHECK YES OR NO**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Brain (stroke, epilepsy) | YES☐ | NO☐ | Breast | YES☐ | NO☐ | Face (Paralysis) | YES☐ | NO☐ |
| Lungs | YES☐ | NO☐ | Urinary System | YES☐ | NO☐ | Nose (Sinus) | YES☐ | NO☐ |
| Eyes | YES☐ | NO☐ | Neverous System | YES☐ | NO☐ | Heart (Vascular Disorders) | YES☐ | NO☐ |
| Liver | YES☐ | NO☐ | Bones/Joints | YES☐ | NO☐ | Ears | YES☐ | NO☐ |
| Reproductive (Male, Female) | YES☐ | NO☐ | Blood | YES☐ | NO☐ | Stomach | YES☐ | NO☐ |
| Intestines | YES☐ | NO☐ | Endocrine (Diabetes) | YES☐ | NO☐ | Arms/Legs (numbness / soreness) | YES☐ | NO☐ |

*If yes please explain:*

________________________________________

________________________________________

**FAMILY HISTORY – PLEASE CHECK YES OR NO:**

| | YES | NO | |
|---|---|---|---|
| Cancer | ☐ | ☐ | Relation: __________ |
| Diabetes | ☐ | ☐ | Relation: __________ |
| Heart Disease | ☐ | ☐ | Relation: __________ |
| High Blood Pressure | ☐ | ☐ | Relation: __________ |
| Lung Disease | ☐ | ☐ | Relation: __________ |
| Kidney Disease | ☐ | ☐ | Relation: __________ |
| Bleeding Disorders | ☐ | ☐ | Relation: __________ |
| Asthma | ☐ | ☐ | Relation: __________ |