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THE PLASTIC SURGERY GROUP, P.C.

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MEDICAL HISTORY FORM

PATIENT NAME: _____ DATE: _____

PAST MEDICAL HISTORY:

General Health : Good _____ Fair _____ Poor _____

If not "Good", please explain :

HEIGHT: _____ WEIGHT: _____ WEIGHT LOSS: _____ GAIN: _____ IN PAST YEAR: _____ lbs.

HOW LONG AGO WAS YOUR MOST RECENT CHECK-UP? _____

NAME & ADDRESS OF YOUR DOCTOR: _____

PREVIOUS SURGERY (Please list)

Operation	Year	Hospital	Doctor	Local or General Anesthesia?
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PREVIOUS ILLNESSES (Please List): _____

ARE YOU CURRENTLY BEING TREATED FOR ANY ILLNESS OR CONDITIONS? If so, please list:

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES _____ NO _____ if yes, Please list:

Continued on back

CURRENT MEDICATIONS (Please list all medications you are now taking and their dosages, including birth control pills, diuretics or water pills, blood pressure or heart medication, pain medications, or any other prescribed or over the counter medications): _____

WHAT IS YOUR APPROXIMATE DAILY CONSUMPTION OF THE FOLLOWING:

COFFEE OR TEA: _____ TOBACCO: _____ ALCOHOL: _____

OTHER INTOXICATING OR MIND ALTERING DRUGS (SPECIFY): _____

PERTINENT PRE-OPERATIVE INFORMATION:

Have you ever reacted badly to being put to sleep for surgery? No ___ Yes ___

Has any member of your family ever reacted badly to being put to sleep for surgery? No ___ Yes ___

Have you required large amounts of anesthetic for medical or dental procedure? No ___ Yes ___

Have you ever had a bad reaction to local anesthetic(Novacain, etc?) No ___ Yes ___

Are you allergic to adhesive tape? No ___ Yes ___

Are you allergic to suture material? No ___ Yes ___

Have you ever had Scarlet fever or Rheumatic Fever? No ___ Yes ___

Do you have high blood pressure? No ___ Yes ___

Do you bleed unusually easily (from cuts, surgery, tooth extractions, etc)? No ___ Yes ___

Do you bruise easily? No ___ Yes ___

Have you ever had a transfusion for surgery? No ___ Yes ___

Are you a slow or poor healer? No ___ Yes ___

Do you form large scars or keloids? No ___ Yes ___

Have you ever taken steroid medications, cortisone, or ACTH? No ___ Yes ___

Do you have shortness of breath with walking? No ___ Yes ___

Do you have or have you had significant emotional problems? No ___ Yes ___

Are you pregnant? No ___ Yes ___

FAMILY HISTORY:

Give age and State of Health for each:

Mother: _____

Father: _____

Brother(s) _____

Sister(s) _____

Children: _____

HAS ANY RELATIVE HAD:

Tuberculosis: No ___ Yes ___

Cancer: No ___ Yes ___

Diabetes: No ___ Yes ___

Epilepsy: No ___ Yes ___

Heart Disease: No ___ Yes ___

High Blood Pressure: No ___ Yes ___

Blood or Bleeding Disorders: No ___ Yes ___

Asthma or Lung Disease No ___ Yes ___

Signature of patient or other: _____ Date: _____

(If "other" please indicate relation): _____