IMPORTANT:
Please fill out this form completely and sign.

SPECIALISTS IN PLASTIC SURGERY, P.A.
PATIENT MEDICAL HISTORY

CHART #: _____

AGE: _____

NAME: _____
LAST *FIRST* *MIDDLE*

DOB: _____/_____/_____

GENDER: _____

LIST ALL DRUG, FOOD AND LATEX ALLERGIES:_____

HEIGHT: _____

WEIGHT: _____

LIST ALL MEDICATIONS *(INCLUDE OVER THE COUNTER AND HOMEOPATHIC MEDICINES)*

	MEDICINE	AMOUNT	HOW OFTEN
1.			
2.			
3.			
4.			
5.			

WHAT IS YOUR AVERAGE DAILY CONSUPTION? **DO YOU SUSPECT THAT YOU MAY BE PREGNANT?**_____

TOBACCO_____ packs per day ALCOHOL_____ amount **DATE OF LAST MAMMOGRAM**_____

PLEASE LIST ALL OPERATIONS THAT YOU HAVE HAD:

	SURGERY	YEAR	SURGEON
1.			
2.			
3.			
4.			

HAVE YOU BEEN HOSPITALIZED FOR ANY OTHER REASON? _____

HAVE YOU OR ANY OF YOUR RELATIVES HAD ANY PROBLEMS WITH ANESTHESIA? YES ☐ NO ☐

IF YES PLEASE EXPLAIN_____

PLEASE CIRCLE IF YOU HAVE OR EVER HAD ANY PROBLEMS WITH ANY OF THE FOLLOWING

1. Heart trouble	6. Diabetes	11. Glaucoma	16. Skin problems	21. Emotional/ Psychiatric problems
2. High blood pressure	7. Jaundice, Hepatitis or Liver problems	12. Cancer	17. Scarlet/ Rheumatic Fever	22. Sleep Apnea
3. Asthma	8. Chronic headache	13. Bleeding disorders	18. Keloid scars	23. Motion Sickness
4. Lung problems	9. Leg, Back, or Neck pains	14. Convulsions	19. Blood clots	
5. Shortness of breath	10. Fainting	15. Kidney problems	20. Stomach/ Intestinal	

FAMILY HISTORY
List any family history of significant illness (for example: heart disease, diabetes, melanoma, malignant hyperthermia, breast cancer)

_____

PLEASE ELABORATE ON ANY MEDICAL INFORMATION THAT MIGHT BE HELPFUL.

_____

DO YOU HAVE KNOWLEDGE THAT YOU ARE HIV POSITIVE (THE AIDS VIRUS), THAT YOU HAVE BEEN EXPOSED TO SOMEONE WHO IS HIV POSITIVE, OR HAVE RISK FACTORS WHICH PLACE YOU AT HIGH RISK FOR HIV? YES ☐ NO ☐

SIGNATURE_____ **DATE**_____