

# Health History

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Please answer all of the questions as accurately as possible in order for our doctor to provide the very best quality care. If you do not understand the question please ask for assistance.

Reason for your visit \_\_\_\_\_

Have you been seen by another Plastic Surgeon \_\_\_\_\_ no yes (if yes, who)? \_\_\_\_\_

Smoking type & amount per day: \_\_\_\_\_ Alcohol (type & amount per week): \_\_\_\_\_

If former smoker, date quit: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Drug Allergies or other: \_\_\_\_\_

List Previous Surgeries or major illnesses & dates: \_\_\_\_\_

List any medications you are taking, *including non-prescription drugs*, vitamins and herbals: \_\_\_\_\_

## Family History:

Has any blood relative ever had the following:

Breast cancer _____ no yes	High blood pressure _____ no yes	Kidney disease _____ no yes
Melanoma _____ no yes	Heart disease _____ no yes	Depression _____ no yes
Stroke _____ no yes	Diabetes _____ no yes	Other(s) _____

## Past Medical History:

Have you ever had the following:

Heart disease _____ no yes	Cancer _____ no yes	Stomach ulcer _____ no yes
Arthritis _____ no yes	Glaucoma _____ no yes	Kidney disease _____ no yes
Rheumatic fever _____ no yes	Asthma _____ no yes	Thyroid disease _____ no yes
Anemia _____ no yes	Aids or HIV+ _____ no yes	Bleeding tendency _____ no yes
Tuberculosis _____ no yes	Stroke _____ no yes	Mitral valve prolapse _____ no yes
Diabetes _____ no yes	Hepatitis _____ no yes	High blood pressure _____ no yes

## Review of Systems

Do you have now or have you had within the past year:

Weight change _____ no yes	Swollen feet/ankles _____ no yes	Seizures _____ no yes
Dry eyes _____ no yes	Skin rash _____ no yes	Joint or muscle pain _____ no yes
Chronic cough _____ no yes	Chronic diarrhea _____ no yes	Swollen lymph nodes _____ no yes
Chest pain _____ no yes	Jaundice _____ no yes	Easy bleeding _____ no yes
Rapid heart beat _____ no yes	Depression _____ no yes	Easy bruising _____ no yes

## Woman Only:

Number of pregnancies \_\_\_\_\_ Date of last mammogram \_\_\_\_\_

Do you do regular self breast examinations \_\_\_\_\_ no yes Breast lump or discharge \_\_\_\_\_ no yes

I verify that the above information is true and accurate to the best of my knowledge.

X \_\_\_\_\_  
Signature of patient or parent if minor

\_\_\_\_\_ Date