

MEDICAL HISTORY

Patient Name _____ **DOB** _____ **Age** _____

Reason for Visit: _____

Referring Physician: _____

Address: _____

City: _____ State : _____ Zip: _____

Height _____ Weight _____ Weight loss or gain in the past year? Y / N
 Amount of weight: Loss _____ Gain _____

When was your most recent physical check-up? _____

Medical Conditions: Please mark all that apply

- Heart Disease
 - High Blood Pressure
 - High Cholesterol
 - Diabetes
 - Chronic Lung Disease
- Other: _____

Medications	Dosage	Frequency

Are you allergic to any medications? No Yes

If yes, which ones?

Drug	Reaction

Surgeries & Hospitalization History	Dates

Circle If you are interested in any of the following procedures:

- Rhinoplasty
- Face Lift
- Eyelid Surgery
- Abdominoplasty
- Liposuction
- Brow Lift
- Breast: Augmentation/ Lift/ Reduction

Burt and Will Plastic Surgery and Laser Centre

Patient Name: _____

Social History

Occupation: _____

Please indicate daily consumption of each of the following:

Tobacco _____

Alcohol _____

Family History: Mark all that apply

- Heart Disease
- High Blood Pressure
- Stroke
- Diabetes
- Mental Disease
- Cancer

Other: _____

Pertinent Preoperative 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 local anesthetic for medical or dental procedures?	No	Yes	_____
Have you ever had a bad reaction to local anesthetic (Novocain, etc.)?	No	Yes	_____
Are you allergic to adhesive tape?	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)?	No	Yes	_____
Do you bruise easily?	No	Yes	_____
Have you required transfusion for surgery?	No	Yes	_____
Are you a slow or poor healer?	No	Yes	_____
Do you form large scars or keloids?	No	Yes	_____
Do you have any skin disease, hives, eczema or rashes?	No	Yes	_____
Do you have frequent infections or boils?	No	Yes	_____
Have you taken steroid medications, cortisone, or ACTH?	No	Yes	_____
Do you have shortness of breath with walking?	No	Yes	_____
Do you have chest pain?	No	Yes	_____
Does your religion prohibit blood transfusions?	No	Yes	_____
Do you have, or have you had any significant emotion problems?	No	Yes	_____
Have you ever had psychiatric care?	No	Yes	_____
Have you ever been advised to see a psychiatrist?	No	Yes	_____
Are you pregnant?	No	Yes	_____
Have you had a mammogram?	No	Yes	_____

If yes, when ? _____