

History Intake Form**Plastic Surgery**

Patient Name: _____ Birth Date: _____

Chief Complaint (s) _____

Please answer all of the questions as accurately as possible. If you do not understand the question please ask for assistance.

Primary Care Doctor: _____

Social History

Do you drink over 6 cups of coffee daily? _____

Smoking (type & amount per day) _____ Alcohol (type & amount per week) _____

If smoker, date quit: _____ Weight _____ Height _____

Drug Allergies: _____

List previous surgeries or major illnesses and dates: _____

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

Do you take Asprin regularly? _____

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	Arthritis	NO	YES

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
Epilepsy	NO	YES	Leukemia	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

Women only:

Age period began _____ Number of pregnancies _____

Date of last mammogram _____ Did you breast feed? NO YES

Do you do regular breast self examinations? _____ 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

NO CHANGE SINCE: _____