LOWCOUNTRY PLASTIC SURGERY CENTER, LLC

HISTORY INTAKE FORM

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

Name: _____ Birthdate:_____Age: _____

Primary Care Doctor: _____ Referring Doctor:_____

Reason for Consultation: _____

Last Physical Exam _____

Drug Allergies: _____

Is your condition related to: _____ Employment _____ Auto Accident _____ Other Accident _____ Cosmetic

Previous Surgeries and Major Illnesses with Dates

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Medications (Including Non-Prescription Drugs, Vitamins and Herbals)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PAST MEDICAL HISTORY

Have you ever had any of the following?

Glaucoma	no yes	Asthma	no yes	Stomach Ulcer	no yes
Anemia	no yes	Tuberculosis	no yes	Kidney Disease	no yes
Diabetes	no yes	Heart disease	no yes	Hepatitis	no yes
Cancer	no yes	Rheumatic Fever	no yes	Stroke	no yes
AIDS or HIV+	no yes	Mitral Valve Prolapse	no yes	Arthritis	no yes
Thyroid Disease	no yes	High Blood Pressure	no yes	Psychiatric Treatment	no yes
Personal history of bleeding problems	no yes	Family history of bleeding problems	no yes		

REVIEW OF SYSTEMS

Do you have now or have you had within the past year any of the following? _____**Check here if none of the following.**

Fatigue	yes	Nosebleeds	yes	Chest pain	yes	Muscle pain	yes
Fever	yes	Vision changes	yes	Rapid heartbeat	yes	Swollen feet/ankles	yes
Weight gain	yes	Dry eyes	yes	Abdominal pain	yes	Skin rash	yes
Weight loss	yes	Watering eyes	yes	Nausea/Vomiting	yes	Skin lesion (mole)	yes
Diabetes	yes	Glasses	yes	Diarrhea	yes	Dizziness	yes
Easy bleeding	yes	Contact lenses	yes	Constipation	yes	Numbness	yes
Easy bruising	yes	Neck pain	yes	Hernia	yes	Seizures	yes
Swollen lymph nodes	yes	Chronic cough	yes	Joint pain	yes	Anxiety	yes
Recent infection	yes	Wheezing	yes	Back pain	yes	Depression	yes

SOCIAL HISTORY

Smoking (type and amount per day):_____ ____Alcohol (type and amount per day): _____

If former, smoker date quit: _____ ____Height: _____ ____Weight: _____

FAMILY HISTORY

Has any blood relative had any of the following?

Breast Cancer	no yes	Stroke	no yes	Diabetes	no yes
Melanoma	no yes	High Blood Pressure	no yes	Kidney Disease	no yes
Other cancer (list below)	no yes	Heart Disease	no yes	Depression	no yes

Other medical problems _____

FOR WOMEN ONLY

Age period began _____	Number of pregnancies _____	Nipple discharge	yes
Date of last mammogram _____	Did you breast feed? yes	Breast mass	yes
Do you do regular breast self-examinations? yes		Breast pain	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