MADISON PLASTIC SURGERY, P.C.

Plastic & Reconstructive Surgery

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Patient History Form

Social

Age: _____ Sex: M ☐ F ☐ Married: Y ☐ N ☐ Occupation: _____

Is a responsible adult available to assist during recovery period? Y ☐ N ☐ Relationship: _____

Habits

Smoker Y ☐ N ☐ Amount _____ Coffee/Tea/Cola: Y ☐ N ☐ Amount _____

Alcohol Y ☐ N ☐ Amount _____ Daily Exercise Y ☐ N ☐ Amount _____

Medications

List medications and number of pills per day:

Prescription: Non-Prescription (Vitamins, Herbs):

_____ _____

_____ _____

_____ _____

_____ _____

Regular aspirin use: Y ☐ N ☐ Dosage & frequency: _____

Advil, Motrin, Ibuprofen Y ☐ N ☐ Dosage & frequency: _____

Cortisone injection in past year Y ☐ N ☐ Date(s) and injection locations: _____

Drug allergy Y ☐ N ☐ List drug(s) and type of reaction: _____

Purifiers, inhalers Y ☐ N ☐ _____

Latex allergy Y ☐ N ☐ _____

Tape allergy Y ☐ N ☐ _____

Family History:

Have any of your blood relations ever had the following problems:

Abnormal breathing: Y ☐ N ☐ Coronary surgery: Y ☐ N ☐ Kidney disease: Y ☐ N ☐

Abnormal clotting: Y ☐ N ☐ Diabetes: Y ☐ N ☐ Tuberculosis: Y ☐ N ☐

Anesthetic problems : Y ☐ N ☐ Heart attack: Y ☐ N ☐ Other serious illness: Y ☐ N ☐

Cancer: Y ☐ N ☐ Hypertension Y ☐ N ☐

Please describe the items from the list above for which you answered "Y" :

_____

_____

_____

Personal History

Have you ever had any of the following problems:

Abnormal breathing:	Y ☐ N ☐	Asthma:	Y ☐ N ☐	Heart attack:	Y ☐ N ☐
Abnormal clotting:	Y ☐ N ☐	Atrial Fibrillation:	Y ☐ N ☐	Hepatitis:	Y ☐ N ☐
Acid regurgitation	Y ☐ N ☐	Diabetes:	Y ☐ N ☐	Hypertension:	Y ☐ N ☐
Anemia:	Y ☐ N ☐	Fainting spell:	Y ☐ N ☐	Mitral valve prolapse:	Y ☐ N ☐
Angina:	Y ☐ N ☐	Prostate disorders:	Y ☐ N ☐	Skin conditions:	Y ☐ N ☐
Urination problems:	Y ☐ N ☐			Weight change in past 12 months	Y ☐ N ☐
Stomach problems:	Y ☐ N ☐			Other serious illness:	Y ☐ N ☐
Ulcers:	Y ☐ N ☐				

Please describe the items from the list above for which you answered "Y" :

_____

_____

_____

Have you ever received a transfusion? Y ☐ N ☐ If yes, in what year? _____

Have you been tested for HIV? Y ☐ N ☐ If yes, in what year? _____

Test results: Positive ☐ Negative ☐

Do you wear any of the following? Contact lenses Y ☐ N ☐ Eyeglasses Y ☐ N ☐

Hearing aid Y ☐ N ☐ Dentures Y ☐ N ☐

Previous surgery, year, and type of procedure: :

_____

_____

_____

Indicate the type(s) of anesthesia received in the past, and list any complications or reactions you experienced

- ☐ Local anesthesia _____
- ☐ General anesthesia _____
- ☐ Spinal/epidural _____

Primary care physician:

Name : _____ Date of last visit: _____

Address: _____ Telephone ( )

Women patients only:

Number of pregnancies _____ Number of children: _____

Did you breast feed? Y ☐ N ☐ Last menstrual period: _____