

GENERAL HEALTH INFORMATION

NAME _____ HEIGHT _____ WEIGHT _____

REASON FOR VISIT: COSMETIC (breast augmentation, liposuction, tummy tuck, etc....)

LACERATION SKIN LESIONS WOUND OTHER _____

PAST MEDICAL HISTORY: Do you now have or have you ever had the following disorders?

DIABETES	IRREGULAR HEART BEAT	THYROID PROBLEMS
HIGH BLOOD PRESSURE (HYPERTENSION)	HEART MURMUR	EASY BRUISING
SEIZURE	RHEUMATIC FEVER	POOR CIRCULATION
STROKE	CHEST PAIN	ANEMIA
HEART ATTACK	SHORTNESS OF BREATH	BLOOD DISORDERS
HEART FAILURE	LUNG DISEASE	PSYCHIATRIC PROBLEMS
ULCERS	COPD	DEPRESSION
BLEEDING DISORDERS	TB	ANXIETY
ASTHMA	CANCER	NERVE PROBLEMS
KIDNEY DISEASE	HEPATITIS	SINUS PROBLEMS
DECREASED VISION	DRY EYE	EXCESSIVE TEARING
WOUND HEALING PROBLEMS	KELOIDS	EXCESSIVE SCAR FORMATION
PREVIOUS BLOOD TRANSFUSION		

ANY CONDITIONS NOT LISTED ABOVE? _____

Are you currently under the care of another doctor for, or have you ever been treated for, any significant illness other than colds / flu? No or Yes: _____

SURGERY: Please list all operations you have had with dates / hospitals if known.

MEDICATIONS: List all medications you take, including "the pill," aspirin, over the counter medications, herbal supplements, vitamins, and blood thinners.

ALLERGIES: List all allergies to medications, food, tape, iodine, soap, etc.

DO YOU SMOKE? Yes or No # of Packs per Day _____
DO YOU DRINK ALCOHOL? Yes or No # of Drinks per Week _____
Have you or your family members had any problems with general anesthesia? Yes or No
Do you mother, father, brothers, or sisters have any medical problems?

Female Patients:
When was your last menstrual period? _____ When was your last mammogram? _____
Are you pregnant or trying to become pregnant? Yes or No Are you breastfeeding? Yes or No