

HISTORY & PHYSICAL EXAMINATION

NAME: _____ **AGE:** _____ **HT:** _____ **WT:** _____

REASON FOR VISIT: BREAST AUGMENTATION TUMMY TUCK
 LIPOSUCTION EYELID SURGERY FACE LIFT
 OTHER _____

HPI:

PMH: **LIST ALLERGIES TO MEDICATION OR LATEX:** _____

LIST YOUR MEDICAL PROBLEMS: **LIST ANY SURGERY YOU HAVE HAD:** **LIST THE MEDS YOU TAKE:**

HAVE YOU OR A FAMILY MEMBER EVER HAD A PROBLEM WITH ANESTHESIA? Y/N

FAMILY HX: **LIST ANY MEDICAL PROBLEMS THAT YOUR FAMILY HAS:**

DOES ANYONE IN YOUR FAMILY HAVE BREAST CANCER? ? Y/N

SOCIAL HX: **DO YOU SMOKE** Y/N **DO YOU DRINK ALCOHOL** Y/N

ROS: N/V F/C WT LOSS CHANGE IN VISION CP/SOB ABD PAIN
DYSURIA/HEMATURIA DIARRHEA/CONSTIPATION WEAKNESS
JOINT PAIN/NUMBNESS IN EXTREMITIES DEPRESSION/ANXIETY

PE: BP R T P
WD/WN NAD HEENT: N/CAT/EOMI _____
PULM-CTA CV SR
ABD SOFT/NT ND
NO HSM
BREASTS NO MASS/NAC D/C NO AX/S-C LAN
 WIDTH _____
EXT NO CCE _____
NEURO WNL

A:

P:

REVIEWED R'S B'S & A'S AS OUTLINED ON CONSENTS

CPT: _____

ICD: _____

Marc S. Scheiner, M.D.

Date: _____