The Peer Group for Plastic Surgery, P.A.

PATIENT'S PERSONAL HISTORY

Date:________________________

CONFIDENTIAL RECORD: Information contained here will not be released except when you have authorized us to do so. Please answer **all** questions to the best of your knowledge. The information provided by you will be used by your doctor in his decision regarding your care.

Last Name______________________________ First Name ________________________ Middle________ DOB ________

Age____________ Ht____________ Wt____________ Sex: M F Marital Status: S M W D or Separated

Date of Last Physical Examination ___________________________________ Dr. ____________________________________

Referring Physician or Party _________________________________ Physician's Phone #: ___________________________

DO YOU HAVE, OR HAVE YOU HAD: (Check All That Apply & List Date(s) of Occurrence)

- ❐ Hay Fever___________________
- ❐ Pneumonia ___________________
- ❐ Bronchitis ___________________
- ❐ Asthma ___________________
- ❐ Tuberculosis ___________________
- ❐ Hypertension___________________
- ❐ Heart Attack ___________________
- ❐ Congenital Heart Disease________
- ❐ Rheumatic Heart Disease________
- ❐ Hepatitis ________________
- ❐ Stomach Ulcers____________
- ❐ Colitis __________________
- ❐ Kidney Disease ____________
- ❐ Bladder Infection___________
- ❐ Goiter____________________
- ❐ Diabetes _________________
- ❐ Arthritis__________________
- ❐ Leukemia_________________
- ❐ Bleeding Tendency________________
- ❐ Cancer ___________________________
- ❐ HIV + ___________________________
- ❐ Migraine Headache________________
- ❐ Epilepsy _________________________
- ❐ Stroke___________________________
- ❐ Latex Allergies ___________________
- ❐ Psychiatric Treatment______________
- ❐ Cold Sores/ Herpes/ Fever Blisters _____________

❐ No ❐ Yes Do you smoke regularly? How much? _________________ How many years? ________________

❐ No ❐ Yes Date of last chest x-ray _______________________________

❐ No ❐ Yes Do you regularly drink alcohol or beer? How much?________________________

❐ No ❐ Yes Have you ever had an adverse reaction to anesthesia?

❐ No ❐ Yes Do you have a history of excessive bleeding following an injury or dental/ surgical procedure?

❐ No ❐ Yes Do you take aspirin or Ibuprofen regularly? How often? ____________________

❐ No ❐ Yes Do you have a "living will"?

ARE YOU PRESENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS? (Check)

- ❐ Aspirin, Bufferin, Anacin
- ❐ Advil, Nuprin, Ibuprofen
- ❐ Medicine for Arthritis
- ❐ Cortisone
- ❐ Blood Thinning Pills
- ❐ Blood Pressure Pills
- ❐ Water Pills
- ❐ Herbal/ Holistic Supplements
- ❐ Heart Medication
- ❐ Digoxin
- ❐ Hormones
- ❐ Birth Control Pills
- ❐ Insulin or Diabetic Pills
- ❐ Thyroid Medication
- ❐ Iron or Anemia Medication
- ❐ Sleeping Pills
- ❐ Tranquilizers
- ❐ Barbiturates
- ❐ Dilantin
- ❐ Phenobarbital
- ❐ Headache Pills
- ❐ Antibiotics

PLEASE LIST ALL CURRENT MEDICATIONS AND THEIR DOSAGES

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

List the names and dates of any operations which you have had:____________________________________

____

Are you allergic to any drugs or latex? ____

____

Serious illnesses or injuries which you have had: ____

____

WOMEN ONLY

❐ No ❐ Yes Are you still having regular monthly menstrual periods?

❐ No ❐ Yes Have you ever had a discharge from the nipple of your breast? When? _______________________

❐ No ❐ Yes Do you regularly have PAP smears of the cervix? Date of last test______________________

How many pregnancies? ______________________________ Cesarean Deliveries ❐ No ❐ Yes

Date of last Mammogram ______________________________

NOTE: We recommend regular breast and pelvic exams by your regular physician for all adults.

8/2005