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 #: ______________________

Pharmacy Name ______________________ Pharmacy 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______________
- ❒ Nervous Breakdown______________
- ❒ 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:______________________

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Name any drugs to which you are allergic: ______________________

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Latex allergy ❒ no ❒ yes

Serious illnesses or injuries which you have had: ______________________

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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.