

PACIFIC CENTER FOR PLASTIC SURGERY

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MEDICAL HISTORY

Name: _____ Sex: _____ Age: _____ DOB: _____

Reason for Visit (chief complaint including date of onset): _____

Height: _____ Weight: _____

DO YOU OR HAVE YOU EVER HAD:

| Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | HIGH BLOOD PRESSURE | <input type="checkbox"/> | <input type="checkbox"/> | BLEEDING TENDENCIES | <input type="checkbox"/> | <input type="checkbox"/> | SYNCOPE |
| <input type="checkbox"/> | <input type="checkbox"/> | STROKE | <input type="checkbox"/> | <input type="checkbox"/> | ANEMIA | <input type="checkbox"/> | <input type="checkbox"/> | SWOLLEN GLANDS |
| <input type="checkbox"/> | <input type="checkbox"/> | HEART ATTACK | <input type="checkbox"/> | <input type="checkbox"/> | AIDS/HIV | <input type="checkbox"/> | <input type="checkbox"/> | GLASSES/CONTACTS |
| <input type="checkbox"/> | <input type="checkbox"/> | IRREGULAR HEART BEATS | <input type="checkbox"/> | <input type="checkbox"/> | TRANSFUSIONS | <input type="checkbox"/> | <input type="checkbox"/> | VISUAL IMPAIRMENT/DRY EYE |
| <input type="checkbox"/> | <input type="checkbox"/> | THROMBOPHLEBITIS/BLOOD CLOTS | <input type="checkbox"/> | <input type="checkbox"/> | DIABETES | <input type="checkbox"/> | <input type="checkbox"/> | CATARACTS |
| <input type="checkbox"/> | <input type="checkbox"/> | RHEUMATIC FEVER/HEART MURMUR | <input type="checkbox"/> | <input type="checkbox"/> | THYROID PROBLEMS | <input type="checkbox"/> | <input type="checkbox"/> | FREQUENT EAR PROBLEMS |
| <input type="checkbox"/> | <input type="checkbox"/> | CHEST PAIN | <input type="checkbox"/> | <input type="checkbox"/> | HEPATITIS/JAUNDICE | <input type="checkbox"/> | <input type="checkbox"/> | FREQUENT NASAL BLEEDING |
| <input type="checkbox"/> | <input type="checkbox"/> | SHORTNESS OF BREATH | <input type="checkbox"/> | <input type="checkbox"/> | KIDNEY DISEASE | <input type="checkbox"/> | <input type="checkbox"/> | SKIN PROBLEM REQUIRING MEDS |
| <input type="checkbox"/> | <input type="checkbox"/> | ASTHMA/EMPHYSEMA/WHEEZING | <input type="checkbox"/> | <input type="checkbox"/> | BLOODY STOOL | <input type="checkbox"/> | <input type="checkbox"/> | MENTAL ILLNESS |
| <input type="checkbox"/> | <input type="checkbox"/> | COLLAGEN VASCULAR DISEASE | <input type="checkbox"/> | <input type="checkbox"/> | BOWEL OBSTRUCTIONS | <input type="checkbox"/> | <input type="checkbox"/> | BREAST LUMPS OR DISCHARGE |
| <input type="checkbox"/> | <input type="checkbox"/> | PNEUMONIA | <input type="checkbox"/> | <input type="checkbox"/> | STOMACH ULCERS | <input type="checkbox"/> | <input type="checkbox"/> | BREAST IMPLANTS |
| <input type="checkbox"/> | <input type="checkbox"/> | BACK OR NECK INJURIES | <input type="checkbox"/> | <input type="checkbox"/> | BLADDER INFECTION | <input type="checkbox"/> | <input type="checkbox"/> | HERNIA OF: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | COLD SORES/HERPES | <input type="checkbox"/> | <input type="checkbox"/> | ABNORMAL X-RAY/MAMMOGRAM | <input type="checkbox"/> | <input type="checkbox"/> | RECENT WEIGHT LOSS OR GAIN |
| <input type="checkbox"/> | <input type="checkbox"/> | SEXUALLY TRANSMITTED DISEASE | <input type="checkbox"/> | <input type="checkbox"/> | SEIZURES | <input type="checkbox"/> | <input type="checkbox"/> | AMOUNT: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | INJURIES OR FRACTURES: WHERE/WHEN?: _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> | CANCER OF/DATE: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | OTHER: _____ | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | MEDICATIONS (include vitamins/herbs/over-the-counter): _____ | | | | | | |

ALLERGIES & SIDE EFFECTS: _____

OPERATIONS/HOSPITALIZATIONS/ER VISITS/COSMETIC PROCEDURES (LIST & DATE): _____

PRIMARY CARE DOCTOR: _____ Phone: () _____ LAST EXAM: _____

GYNECOLOGIST: _____ Phone: () _____ LAST EXAM: _____

ONSET OF LAST MENSTRUAL CYCLE: (Date) _____ REGULAR IRREGULAR

NUMBER OF PREGNANCIES: _____ NUMBER OF BIRTHS: _____ METHOD OF BIRTH CONTROL: _____

COULD YOU BE PREGNANT NOW? YES NO

| | | |
|--|--|---|
| <input type="checkbox"/> <input type="checkbox"/> FAMILY HISTORY OF DISEASE : (LIST FAMILY MEMBER AND DATE) | <input type="checkbox"/> DIABETES _____ | <input type="checkbox"/> CANCER _____ |
| | <input type="checkbox"/> STROKE _____ | <input type="checkbox"/> HYPERTENSION _____ |
| | <input type="checkbox"/> HEART DISEASE _____ | <input type="checkbox"/> OTHER _____ |

SOCIAL HISTORY

DO YOU SMOKE? YES/How Much? _____ NO/Date Quit: _____ NEVER

DO YOU DRINK ALCOHOL? YES/How Often? _____ NO

LABORATORY STUDIES

(DATE & LOCATION)

| Yes | No | | Yes | No | |
|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | BLOOD TESTS (CBC) _____ | <input type="checkbox"/> | <input type="checkbox"/> | CHEST X-RAY/MRI/CT _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | EKG (CARDIOGRAM) _____ | <input type="checkbox"/> | <input type="checkbox"/> | OTHER LAB _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | MAMMOGRAM Date: _____ Location: _____ | | | |

I certify that I have disclosed my medical history to the best of my knowledge.

Patient's Signature

Date