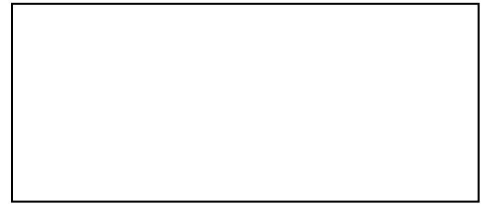

PATIENT MEDICAL HISTORY
PLASTIC & RECONSTRUCTIVE SURGERY

Name: **Age:** **Occupation:**

Preferred Phone Number: **Email Address:**

Your Pronoun: She/her/hers He/him/his They/them/theirs Other

Reason for Visit *(please be specific)***:**

Medical History *(please check all that apply):*

Arthritis	Cancer Type: Chemotherapy Radiation Therapy Surgery	Diabetes	Pulmonary Embolism
Asthma		Heart Attack	Seizure Disorder
Anxiety		High Blood Pressure	Stroke
Blood clot		High Cholesterol	Thyroid High Low
Depression		Malignant Hyperthermia	

Other Significant Medical Problems *(please list):*

Surgical History *(please check all that apply):*

Breast Surgery Lumpectomy: Right Left Mastectomy: Right Left Other Type:	Abdominal Surgery: Gall bladder: Open laparoscopic Appendix: Open laparascopic Hysterectomy C-section Other Type:
Hand Surgery: Right Left Are you right-handed or left-handed? Right Left	Weight Loss Surgery: Bypass Sleeve Lap band What was your highest weight? What do you weigh now? How long has your weight been stable?
Heart Surgery: Stent Bypass Are you on blood thinners? Yes No	Skin Cancer: Type Location:

Other Surgeries *(please list):*

Medications *(please list):*

Allergies *(please list):*

Social History *(please select yes or no):*

Do you smoke? Yes No If yes, how much per day?

Do you drink alcohol? Yes No If yes, how much per day?

Do you currently use any unprescribed drugs (ex. Marijuana, cocaine, etc.) Yes No

Family History *(please check all that apply):*

Relationship	Arthritis	Birth Defects	Breast Cancer	Ovarian Cancer	Other Cancer	Depression	Heart Disease	High Blood Pressure	Melanoma	Stroke
Mother										
Father										
Sister										
Brother										

Any Other Significant Family History *(please list):*

What was the date of your last mammogram (*if applicable)*?

Do you experience pain as part of your daily life *(please select yes or no):* Yes No

If yes, please rate your pain on a scale of 1-10 (0 = none, 10 = worst possible):

How do you treat your pain? Heat Ice Massage Medication Other

Falls Screening *(please select yes or no)*:

Have you fallen and hurt yourself in the past year? Yes No

Have you fallen 2 or more times in the past year? Yes No

Are you afraid that you might fall because of balance or walking problems? Yes No

Comments:

Photography Consent *(please select yes or no):*

I understand that insurance companies may require photographs in order to evaluate claims. I give consent for the submission of photographs to insurance companies. I also understand that these photographs may be used for medical education. Yes No

Comments:

Please leave this space blank for provider.