RAYMOND A. CAPONE, JR, M.D.

Plastic & Reconstructive Surgery
5727 Centre Avenue Pittsburgh, PA 15206~(412)363-6626~Fax(412)363-7008

CONFIDENTIAL MATERIAL

Patient's Name_____Appointment Date_____

MEDICAL HISTORY

YES	NO	
❑	❑	Have you ever had a heart condition?
❑	❑	A heart murmur?
❑	❑	A heart attack?
❑	❑	Angina?
❑	❑	Have you ever had a lung condition?
❑	❑	Have you ever had asthma?
❑	❑	Any episodes of pneumonia?
❑	❑	Do you smoke? Cigarettes _____Cigars _____ Pipe_____ How many packs a day? _____ How many years? _____ If not, when did you quit? _____
❑	❑	Have you ever had a liver condition?
❑	❑	Any episodes of hepatitis or yellow jaundice?
❑	❑	Are you HIV +
❑	❑	Do you have a history of MRSA infection?
❑	❑	Do you frequent nursing homes or hospitals?
❑	❑	Do you drink alcoholic beverages? How much per day? _____ How much per week? _____
❑	❑	Have you ever had a kidney condition?
❑	❑	Any kidney stones?
❑	❑	Any kidney infections?
❑	❑	Have you ever had any skin conditions?
❑	❑	Any rashes now?
❑	❑	Any keloid scars?
❑	❑	Have you ever had hypertension (high blood pressure)?

❑ ❑ Have you ever been told you or one of your relatives have Malignant Hyperthermia?
❑ ❑ Have you ever had phlebitis (clots in leg veins)?

R L Which is your dominant hand?

YES NO
❑ ❑ Have you ever become nauseous after surgery?
❑ ❑ Has any pain prescription ever made you nauseous?
Please list those that have made you sick _____
List any that work well for you _____
❑ ❑ Do you get motion sickness or sea sickness?
❑ ❑ Do you take birth control or hormone pills?
❑ ❑ If female, are you pregnant?
❑ ❑ Have you ever had a stomach condition?
❑ ❑ Have you ever had any unusual bleeding tendencies?
❑ ❑ Have you had a nosebleed in the last year?
❑ ❑ Do you have more than two bruises now?
❑ ❑ Have you ever had excessive bleeding following a surgical procedure?
❑ ❑ Does anyone in your family have unusual bleeding tendencies?

List any surgical procedures that you have had? (Please list any complications)

_____Date _____

_____Date _____

_____Date _____

_____Date _____

_____Date _____

List any medications you take regularly: _____
_____
_____

List any herbal remedies you take regularly: _____
_____

❑ ❑ Have you ever had an allergic reaction?
❑ ❑ Have you ever had an allergic reaction to skin tape or ointments?
❑ ❑ Are you allergic to Latex? If yes, the type of reaction and when? _____
❑ ❑ Are you allergic to Penicillin? If yes, the type of reaction and when? _____
❑ ❑ Are you allergic to Keflex? If yes, the type of reaction and when? _____
❑ ❑ Have you or one of your relatives ever had an allergic reaction to anesthesia?

List any items or medicines, tapes or ointments that you may be allergic to (include type of reaction and when):
_____
_____

Other medical conditions not listed above: _____
_____