Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History

Select any of the following medical conditions that you currently have

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Adrenal Insufficiency  Anemia/Thalassemia  Anxiety  Arthritis  Asthma  Atrial Fibrillation (Irregular Heartbeat)  Auto-Immune Disease  Bipolar Disorder  Blood Clotting Disorder  BPH  Breast Cancer  Colon Cancer  COPD  Coronary Artery Disease  Deep Venous Thrombosis  Depression  Diabetes  Easy Bruising  End Stage Renal Disease  GERD  Head Trauma  Hearing Loss  Hepatitis  Hypertension  Pregnancy: Vaginal Delivery  Cesarean | HIV / AIDS  Hypercholesterolemia  Hyperthyroidism  Hypothyroidism  Lung Cancer  Lupus  Lymphoma  Malignant Hypertension  Mental Health Hospitalization  Neuromuscular Disorder  Paralysis  Pneumothorax  Prostate Cancer  Pulmonary Embolism  Radiation Treatment  Renal Disorder  Rheumatoid Arthritis  Seizures  Severe Reaction to Anesthesia  Stroke  Trauma  Valvular Heart Disease  Vision Loss  None |
| Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

Past Surgeries

Have you had any surgeries on the following organs?

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Abdominal Wall: Hernia Repair, Left Femoral  Abdominal Wall: Hernia Repair, Right Femoral  Abdominal Wall: Hernia Repair, Left Inguinal  Abdominal Wall: Hernia Repair, Right Inguinal  Abdominal Wall: Hernia Repair, Umbilical  Adenoidectomy  Abdominal Wall: Hernia Repair, Ventral  Appendix (Appendectomy)  Bladder (Cystectomy)  Brain: Brain Surgery for Cancer  Brain: Brain Surgery for Trauma  Breast: Mastectomy (Right Breast)  Breast: Mastectomy (Left Breast)  Breast: Mastectomy (Both Breasts)  Breast: Lumpectomy (Right Breast)  Breast: Lumpectomy (Left Breast)  Breast: Lumpectomy (Both Breasts)  Breast: Breast Biopsy  Cesarean Section  Colon (Colectomy): Colon Cancer Resection  Colon (Colectomy): Diverticulitis  Colon (Colectomy): Inflammatory Bowel Disease  Esophagus: Esophagectomy  Gallbladder (Cholecystectomy)  Heart: Coronary Artery Bypass Surgery  Heart: PTCA  Heart: Mechanical Valve Replacement  Heart: Biological Valve Replacement  Heart: Heart Transplant  Joint Replacement: Knee (Right)  Joint Replacement: Knee (Left)  Joint Replacement: Knee (Both)  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Joint Replacement: Hip (Right)  Joint Replacement: Hip (Left)  Joint Replacement: Hip (Both)  Kidney: Kidney Biopsy  Kidney: Nephrectomy  Kidney: Kidney Stone Removal  Kidney: Kidney Transplant  Lung: Left Lower Lobectomy  Lung: Left Pneumonectomy  Lung: Left Upper Lobectomy  Lung: Right Lower Lobectomy  Lung: Right Middle Lobectomy  Lung: Right Pneumonectomy  Lung: Right Upper Lobectomy  Ovaries (Oophorectomy): Endometriosis  Ovaries (Oophorectomy): Ovarian Cyst  Ovaries (Oophorectomy): Ovarian Cancer  Prostate (Prostatectomy: Prostate Cancer  Prostate (Prostatectomy): Prostate Biopsy  Prostate (Prostatectomy): TURP  Skin: Skin Biopsy  Skin: Basal Cell Carcinoma  Skin: Squamous Cell Carcinoma  Skin: Melanoma  Small Bowel Resection  Spine Surgery  Spleen (Splenectomy)  Stomach: Gastrectomy  Testicles (Orchiectomy)  Tonsillectomy  Uterus (Hysterectomy): Fibroids  Uterus (Hysterectomy): Uterine Cancer  None \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Pediatric History

Gestational Age at Birth (in weeks)

Weeks

Birth Weight  lbs  oz

Maternal illness during pregnancy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Forceps delivery Yes No

Skin Disease History

Have you had any of the following skin conditions?

|  |  |
| --- | --- |
| Acne  Actinic Keratoses  Asthma  Basal Cell Skin Cancer  Blistering Sunburns  Dry Skin  Eczema  Other | Flaking or Itchy Scalp  Hay Fever/Allergies  Melanoma  Poison Ivy  Precancerous Moles  Psoriasis  Squamous cell skin cancer  None |

Do you wear Sunscreen?

 Yes    No

If yes, what SPF? \_\_\_\_\_

Do you tan in a tanning salon?

 Yes    No

Family History

List first degree relatives with significant past medical history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History

Do you have a family history of Melanoma?

 Yes   No

If yes, which relative?

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Mother  Father  Sister  Brother  Daughter  Son  Uncle  Other \_\_\_\_\_\_\_\_\_ | Aunt  Nephew  Niece  Grandmother  Grandfather  Grandson  Granddaughter |

Plastic Surgery History

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  | | --- | | Abdomen: Abdominal Wall Reconstruction |  |  | | --- | | Abdomen: Abdominoplasty |  |  | | --- | | Body Contouring: Brachioplasty |  |  | | --- | | Body Contouring: Liposuction |  |  | | --- | | Body Contouring: Lower Body Lift |  |  | | --- | | Body Contouring: Thigh Lift |  |  | | --- | | Body Contouring: Upper Body Lift |  |  | | --- | | Breast: Breast Augmentation |  |  | | --- | | Breast: Breast Lift (Mastopexy) |  |  | | --- | | Breast: Breast Reconstruction |  |  | | --- | | Breast: Breast Reduction |  |  | | --- | | Breast: Correction of Nipple Inversion |  |  | | --- | | Breast: Implant Removal |  |  | | --- | | Breast: Nipple Reconstruction |  |  | | --- | | Burn Wound Reconstruction |  |  | | --- | | Carpal Tunnel Release |  |  | | --- | | Chemical Peel |  |  | | --- | | Cleft Lip Repair |  |  | | --- | | Cleft Palate Repair | |  |  |  | | --- | | Cubital Tunnel Release |  |  | | --- | | Decubitus Ulcer Reconstruction |  |  | | --- | | Dermabrasion |  |  | | --- | | Ears: Ear Reconstruction |  |  | | --- | | Ears: Earlobe repair |  |  | | --- | | Ears: Otoplasty |  |  | | --- | | Face: Blepharoplasty |  |  | | --- | | Face: Brow lift |  |  | | --- | | Face: Cheek Augmentation |  |  | | --- | | Face: Chin Augmentation |  |  | | --- | | Face: Facelift |  |  | | --- | | Face: Facial Fracture Repair |  |  | | --- | | Face: Facial Reanimation |  |  | | --- | | Face: Frontal Sinus Fracture |  |  | | --- | | Face: Frontoorbital Advancement |  |  | | --- | | Face: Lefort Osteotomy | | Other Plastic Surgery History \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | | --- | | Face: Lower Blepharoplasty |  |  | | --- | | Face: Mandible Fracture |  |  | | --- | | Face: Maxillary Fracture |  |  | | --- | | Face: Orbital Floor Fracture |  |  | | --- | | Face: Repair of Craniosynostosis |  |  | | --- | | Face: Upper Blepharoplasty |  |  | | --- | | Face: Zygoma Fracture |  |  | | --- | | Flap Reconstruction |  |  | | --- | | Hair Restoration |  |  | | --- | | Hand: Extensor Tendon Repair(s), Left Upper Extremity |  |  | | --- | | Hand: Extensor Tendon Repair(s), Right Upper Extremity |  |  | | --- | | Hand: Flexor Tendon Repair(s), Left Upper Extremity |  |  | | --- | | Hand: Flexor Tendon Repair(s), Right Upper Extremity |  |  | | --- | | Hand: Ganglion Cyst Removal |  |  | | --- | | Hand: Mallet Finger Repair, Left Upper Extremity | |  |  |  | | --- | | Hand: Mallet Finger Repair, Right Upper Extremity |  |  | | --- | | Hand: Metacarpal Fracture Repair |  |  | | --- | | Hand: ORIF of Fracture, Left Upper Extremity | |  |  |  | | --- | | Hand: ORIF of Fracture, Right Upper Extremity |  |  | | --- | | Hand: Phalangeal Fracture Repair |  |  | | --- | | Hand: Trigger Finger Release, Left Upper Extremity |  |  | | --- | | Hand: Trigger Finger Release, Right Upper Extremity |  |  | | --- | | Hand: Wrist Fracture Repair |  |  | | --- | | Laser Hair Removal |  |  | | --- | | Laser resurfacing - CO2 |  |  | | --- | | Laser resurfacing - Erbium |  |  | | --- | | Nose: Rhinoplasty |  |  | | --- | | Nose: Septoplasty |  |  | | --- | | Orthopedic Hardware Coverage |  |  | | --- | | Scar revision |  |  | | --- | | Skin Graft Reconstruction |  |  | | --- | | Sternal Wound Reconstruction |  |  | | --- | | Tendon Transfer |  |  | | --- | | Vascular Graft Coverage |  |  | | --- | | Wound Reconstruction | |

Breast Cancer

Do you have a family history of breast cancer?

 Yes  No

If so, which relative

|  |  |
| --- | --- |
| Mother  Father  Sister  Brother  Daughter  Son  Uncle  Other \_\_\_\_\_\_\_\_\_\_\_ | Aunt  Nephew  Niece  Grandmother  Grandfather  Grandson  Granddaughter |

|  |
| --- |
|  |

Malignant Hyperthermia and Anesthesia Sensitivity

Do you have a family history of malignant hyperthermia or severe reactions to anesthesia?

 Yes    No

If so, which relative

|  |  |
| --- | --- |
|  | |
| Mother  Father  Sister  Brother  Daughter  Son  Uncle  Other \_\_\_\_\_\_\_\_\_\_\_ | | Aunt  Nephew  Niece  Grandmother  Grandfather  Grandson  Granddaughter | |

Herbal Medications and Supplements

Do you take any herbal medications or supplements?

 Yes   No

Which herbal medications or supplements do you take?

|  |  |
| --- | --- |
| Anabolic Steroids  Androstenedione  Black Cohosh  Cat's Claw  Chondroitin  Cranberry  Echinacea  Ephedra  Evening Primrose  Feverfew  Fish Oil  Flaxseed Oil  Garlic  Gingko Biloba  Ginseng  Glucosamine  Goldenseal  Green tea  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Hawthorn  HCG  Horse Chestnut  Human growth hormone  Kava  Licorice Root  Mistletoe  Peppermint  Phentermine  Red Clover  Saw Palmetto  St. John’s Wort  Valerian  Vitamin A  Vitamin B  Vitamin C  Vitamin D  Vitamin E |

|  |
| --- |
|  |

Medications

List all current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy: Name, Address & Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies:

List all allergies and reactions if known:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation and Workplace:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social History

Social History Details

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Not sexually active  Sexually active with one partner  Sexually active with more than one partner  Same sex partner  Drug use  IV Drug Use  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | EtOH none  EtOH less than 1 drink per day  EtOH 1-2 drinks per day  EtOH 3 or more drinks per day  Patient feels safe at home  Patient feels unsafe at home  Right hand dominant  Left hand dominant  None |

Smoking Status (please choose one)

Current everyday smoker

Current someday smoker

Former smoker

Never smoker

Smoker current status unknown

Unknown if ever smoked

Driving Status

|  |  |
| --- | --- |
| Drives in the Daytime | Drives at Night |

How often do you exercise?

Unspecified

Several times a day

Once a day

A few times a week

A few times a month

Never

Other \_\_\_\_\_\_\_\_\_\_\_\_

What is your caffeine use?

Unspecified

Several times a day

Once a day

A few times a week

A few times a month

Never

Other \_\_\_\_\_\_\_\_\_\_\_\_

Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Contact Method:

 Unspecified  Declined to receive reminders  Patient Portal

 Phone: Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Is it Ok to leave a detailed message:* Yes or No**

 Letter/Fax

Race and Ethnicity:

*Race:*

 Unspecified  Declined to specify  Prohibited by State law

 Prohibited  White  Asian American Indian/Alaska Native

 Black or African American  Native Hawaiian or Pacific Islander

 Other  Other Race  Abenaki

*Ethic Group:*

 Unspecified  Declined to specify  Prohibited by State law

 Hispanic or Latino  Not Hispanic or Latino  Unknown

Review of Systems: Are you currently experiencing any of the following: *(Please check yes or no for the following):*

Abdominal Pain yes no

Anxiety yes no

Bleeding Problems yes no

Bloody Stool yes no

Bloody Urine yes no

Changing Mole yes no

Chest Pain yes no

Cough yes no

Depression yes no

Fever or Chills yes no

Headaches yes no

Hay Fevers yes no

Joint Aches yes no

Muscle Weakness yes no

Neck Stiffness yes no

Night Sweats yes no

Rash yes no

Seizures yes no

Shortness of Breath yes no

Sore Throat yes no

Thyroid Problems yes no

Unintentional Weight loss yes no

Wheezing yes no

Other Symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cautions: *(Circle all that apply)*

Have you ever had difficulty-stopping bleeding? yes no

Do you require antibiotics prior to surgical procedure? yes no

Have you had an artificial joint replacement? yes no

If yes, when and what body locations?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an artificial heart valve? yes no

Do you have a pacemaker? yes no

Do you have a defibrillator? yes no

Are you pregnant or currently trying to get pregnant? yes no

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_