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 InguinalAbdominal Wall: Hernia Repair, Right InguinalAbdominal Wall: Hernia Repair, UmbilicalAdenoidectomy 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 SectionColon (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 EczemaOther  | 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 UncleOther \_\_\_\_\_\_\_\_\_ | 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 UncleOther \_\_\_\_\_\_\_\_\_\_\_ | 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 UncleOther \_\_\_\_\_\_\_\_\_\_\_ | 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 UseOther \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  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 dominantLeft hand dominantNone |

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