

PLASTIC SURGERY CENTER, INC.
PATIENT MEDICAL HISTORY FORM

NAME: _____ AGE: _____ BIRTHDATE: _____

Height: _____ Weight: _____

1. Have you been under the care of a physician for anything other than normal yearly checkups? Y N If yes, please explain _____

Physicians name: _____ Address: _____

2. Current medications you are on: _____

3. Have you ever had an allergic reaction to medication? Y N

4. Are you on any diet medications now? Y N

5. Do you take aspirin? Y N Do you bruise easily? Y N

6. Do you have any of the following medical conditions? Please circle Y N

Heart Murmur	Y	N	Lung problems	Y	N
Palpitations	Y	N	Emphysema	Y	N
Chest Pain	Y	N	Chronic Cough	Y	N
Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N
High Blood Pressure	Y	N	Shortness of Breath	Y	N
Congenital Heart Disease	Y	N	Asthma	Y	N
Dizziness	Y	N	Chest tightness	Y	N
Fainting Spells	Y	N	Pneumonia	Y	N
Headaches	Y	N	Wheezing	Y	N
Migraines	Y	N	Smoking	Y	N
Epilepsy, Seizures	Y	N	Drug Problems	Y	N
Blood disorders	Y	N	Alcoholism	Y	N
Chronic fatigue	Y	N	Thyroid problems	Y	N
Muscle disorders	Y	N	Rash	Y	N
Diabetes	Y	N	Arthritis/Rheumatism	Y	N
Allergic Problems (hives)	Y	N	Ulcers	Y	N
Food Allergies	Y	N	Liver disease	Y	N
Psychiatric/Psychological	Y	N	Hepatitis A or B	Y	N
Nervous/Anxious	Y	N	Venereal Disease	Y	N
Neurological disorders	Y	N	H.I.V. Positive	Y	N
Cortizone Medications	Y	N	Glaucoma	Y	N
Heart attack or Stroke	Y	N	Kidney Disease	Y	N

Last menstrual period _____

6. Do you have any medical condition not listed above? Y N

7. Have you been on a weight management program in the past? Y N

8. Have you lost or gained more than 10 pounds in the past year? Y N

9. Have you had an EKG within the last 6 months? Y N

10. Have you had blood work done during the last 6 months? Y N

11. Do you drink Alcohol? Daily Weekly On Occasion

12. Women: Pregnant? Y N Number of children: _____

13. Have you had a mammogram within the last year? Y N

14. Please list any surgeries you have had: _____

I understand the above information is necessary to provide me with the best care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify Dr. Burnham of any change in my health or medications.

Patient Signature: _____ Date: _____