# SHOALS PLASTIC SURGERY

## PATIENT MEDICAL HISTORY

**Name** _____ **Date** _____

**Age** _____ **Height** _____ **Weight** _____

***Names of other physicians:***

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |

| ***Drug allergies*** | ***Reactions*** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

***Current Medications / Dosage***

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

***Cardiovascular Medical History***

- ☐ Stroke/CVA
- ☐ Migraines
- ☐ Fainting/dizzy spells
- ☐ Seizures/convulsions
- ☐ High blood pressure
- ☐ Shoulder/neck/jaw pain
- ☐ Chest pain/tightness
- ☐ Swelling feet/ankles
- ☐ Phlebitis
- ☐ Rheumatic fever
- ☐ Varicose veins
- ☐ Phlebitis
- ☐ Vein stripping
- ☐ Bleeding problems
- ☐ Anemia
- ☐ Congestive heart failure
- ☐ Abnormal heart rhythm
- ☐ Problem with heart valves
- ☐ Blockages in neck arteries
- ☐ Surgery on neck arteries
- ☐ Pacemaker
- ☐ Heart attack — When
- ☐ Blood clots — Where / When _____
- ☐ Blood transfusion — When / Why _____
- ☐ Pain in legs when walking — Where: buttocks thighs calves
- ☐ Surgery on arteries in legs — Which ones? _____
- ☐ Heart surgery/balloon procedure — When? _____
- ☐ Problem that required blood thinners — _____

***Respiratory System Medical History***

- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Coughed up blood
- ☐ Blood clots to lungs
- ☐ Lung cancer
- ☐ Other lung disease
- ☐ TB
- ☐ Pulmonary edema
- ☐ Are you ever short of breath or feel as though you are smothering?
  If yes, when _____
- ☐ Persistant cough — If yes, do you bring up sputum? _____
  How much? _____ Color? _____
  How many pillows do you sleep on at night? ____

## *General Medical History*

- ☐ Stomach ulcers
- ☐ Hiatal hernia
- ☐ Indigestion/heartburn
- ☐ Gallbladder disease
- ☐ Liver disease
- ☐ Thyroid problems
- ☐ Gout
- ☐ Depression
- ☐ Nerve problems
- ☐ Mental illness
- ☐ Recent wt gain/loss
- ☐ Yellow jaundice
- ☐ Hepatitis
- ☐ Cirrhoisis
- ☐ Diverticulitis
- ☐ Hemorrhoids
- ☐ Broken bones
- ☐ Back problems
- ☐ Arthritis/Rheumatism
- ☐ Hearing problems
- ☐ Hearing aid
- ☐ Colitis
- ☐ Black/tarry/sticky stools
- ☐ Blood in stool
- ☐ Vomited blood
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Glasses
- ☐ Double vision
- ☐ Blurred vision
- ☐ Spots in front of eyes
- ☐ Difficulty urinating
- ☐ Dialysis
- ☐ Prostate problems
- ☐ Venereal disease
- ☐ HIV / AIDS
- ☐ Urinary tract infection
- ☐ Kidney stones
- ☐ Kidney failure
- ☐ Diabetes Age at onset _____
  Controlled by: Diet Insulin Oral medication

Do you exercise on a routine bases? YES NO

How many flights of stairs are you able to walk up?

Is this limited by:
- ☐ Chest pain
- ☐ Pain in legs
- ☐ Shortness of breath
- ☐ Joint problems

## *Patient Surgical History*

- ☐ Appendectomy
- ☐ Gallbladder
- ☐ Stomach
- ☐ Thyroid
- ☐ Problems with anesthesia:
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Colon
- ☐ Lungs
- ☐ Prostate
- ☐ Kidney
- ☐ Hernia
- ☐ Breast ( ) biopsy ( ) mastectomy
- ☐ Heart ( ) valve ( ) bypass ( ) stent
- ☐ Other:
- ☐ Other:

## *Recent hospitalizations other than surgery*

_____

_____

_____

## *Family History*

| Mother | Father | Brother/Sister | Grandmother | Grandfather |
|---|---|---|---|---|
| ☐ Heart | ☐ Heart | ☐ Heart | ☐ Heart | ☐ Heart |
| ☐ Cancer | ☐ Cancer | ☐ Cancer | ☐ Cancer | ☐ Cancer |
| ☐ Diabetes | ☐ Diabetes | ☐ Diabetes | ☐ Diabetes | ☐ Diabetes |
| ☐ TB | ☐ TB | ☐ TB | ☐ TB | ☐ TB |
| ☐ High blood pressure | ☐ High blood pressure | ☐ High blood pressure | ☐ High blood pressure | ☐ High blood pressure |
| ☐ Stroke | ☐ Stroke | ☐ Stroke | ☐ Stroke | ☐ Stroke |
| Living/deceased | Living/deceased | Living/deceased | Living/deceased | Living/deceased |
| Age at death: | Age at death: | Age at death: | Age at death: | Age at death: |

## *Social History*

- ☐ Smoke — If yes, packs per day _____ # of years _____ Cigarettes Cigars Pipe
- ☐ Drink alcohol — If yes, how often? _____
- ☐ Special diet — If yes, what kind? _____

Occupation _____ Marital Status: M W S D

Number of children and ages _____

Who lives at home with you? _____

## *Females*

Number of pregnancies _____

Hysterectomy _____

Menopause _____