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Plastic & Reconstructive Surgery
Diplomate of the American Board of Plastic Surgery

NAME:_____
AGE:_____
DATE:_____
PATIENT'S LEGAL SIGNATURE:_____
MARITAL STATUS: MARRIED___ SINGLE___DIVORCED___SEPARATED___WIDOWED___
Please read each question carefully and answer to the best of your ability.

1. Have you ever been a patient in a hospital? _____YES ____NO
   If yes, please list below:
   YEAR____ REASON
   _____ _____
   _____ _____
   _____ _____
2. List Previous Surgeries:
   YEAR____ OPERATION
   _____ _____
   _____ _____
   _____ _____
3. Do you take aspirin or anti-inflammatories? _____YES_____NO
4. Have you ever had any difficulty with anesthesia? _____YES_____NO
5. Have you ever had any bleeding problems or do you bruise easily? _____YES_____NO
6. Has any blood relative had: Diabetes _____YES_____NO
   Cancer _____YES_____NO
7. Do you smoke? How much?_____ _____YES_____NO
8. Do you take more than two drinks per day? _____YES_____NO
9. Do you take tranquilizers or sedatives? _____YES_____NO
10. Have you changed jobs frequently? _____YES_____NO
11. Have you ***gained*** 5 or more pounds in the past year? _____YES_____NO
12. Have you ***lost*** 5 or more pounds in the past year? _____YES_____NO
13. Are you now taking any medications for any of the following conditions?
    High Blood Pressure ____YES____NO MEDICATION:_____
    Diabetes ____YES____NO MEDICATION:_____
    Gout ____YES____NO MEDICATION:_____
    Anemia ____YES____NO MEDICATION:_____
    Nervousness ____YES____NO MEDICATION:_____
    Sleep Disorders ____YES____NO MEDICATION:_____

Heart Disease ____YES____NO MEDICATION:_____
Thyroid ____YES____NO MEDICATION:_____
Pain Medication ____YES____NO MEDICATION:_____
Laxatives ____YES____NO MEDICATION:_____
Birth Control ____YES____NO MEDICATION:_____
Menopause ____YES____NO MEDICATION:_____
Other(s) ____YES____NO MEDICATION:_____

14. Do you take Vitamins? _____YES_____NO
15. Have you or did you ever have any allergies? _____YES_____NO
    Please give medication and reaction:_____
    _____
16. Have you ever had any of the following illnesses?

Heart Disease ____YES____NO DATE:_____
High Blood Pressure ____YES____NO DATE:_____
Angina ____YES____NO DATE:_____
Ulcer of Stomach ____YES____NO DATE:_____
Pancreatitis ____YES____NO DATE:_____
Colitis ____YES____NO DATE:_____
Diabetes ____YES____NO DATE:_____
Cancer ____YES____NO DATE:_____
Gout ____YES____NO DATE:_____
Kidney Disease ____YES____NO DATE:_____
STD ____YES____NO DATE:_____
Thyroid ____YES____NO DATE:_____
Arthritis ____YES____NO DATE:_____
Convulsions/Seizures ____YES____NO DATE:_____
Anxiety /Depression ____YES____NO DATE:_____
Hepatitis ____YES____NO DATE:_____
Glaucoma ____YES____NO DATE:_____
Anemia ____YES____NO DATE:_____
Scarlet Fever ____YES____NO DATE:_____
Rheumatic Fever ____YES____NO DATE:_____

17. Have you ever received treatment for emotional or nervous disorders? _____YES_____NO
18. Have you ever attempted suicide? _____YES_____NO
19. Have you had any of the following examinations?

Chest X-Ray ____YES____NO DATE:_____
EKG ____YES____NO DATE:_____
Complete Physical ____YES____NO DATE:_____
Blood Tests ____YES____NO DATE:_____