PLASTIC SURGERY SPECIALISTS, P.C.
MEDICAL HISTORY

Date:_____

Name:_____ Age:_____ HT:_____ WT:_____

Primary MD:_____ Referring MD:_____

Pharmacy Name: _____ Address: _____
Number Street

_____
City State Zip Code

Pharmacy Phone Number _____

Reason for Office Visit:_____

Please Circle If You Have A History Of:

☐ Asthma ☐ Emphysema ☐ Colon Disease ☐ High Blood Pressure ☐ Tuberculosis

☐ Diabetes ☐ Epilepsy ☐ Cancer ☐ Abnormal Bleeding/Bruising ☐ Glasses/Contact Lenses

☐ Depression ☐ Stroke ☐ Kidney Disease ☐ Anesthesia Difficulty ☐ Dental Appliances

☐ Heart Attack ☐ Irregular Heart Beat ☐ Heart Valve Disease ☐ Chest Pain

☐ Difficulty Climbing Stairs ☐ Heart Failure ☐ Pacemaker ☐ Heart Surgery

☐ Difficulty Lying Flat ☐ Other Medical Problem

Describe:_____
_____

Do You Smoke? ☐ Yes ☐ No _____ packs per day _____
Office comment

Drug Allergies and Your Reaction:_____

Other Allergies: Food_____ Latex_____ Other_____

Medications and Reason For Taking: (No Dosage Necessary)
_____
_____
_____

Prior Surgeries:_____
_____

Females, Please Complete:

Last Menstrual Period:_____ Pregnant? ☐ Yes ☐ No
Date of Last Mammogram:_____ #Children:_____