Name_____ Date of Birth_____

PLEASE COMPLETE ALL PAGES AND ITEMS -- THANK YOU.

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
- ☐ 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
- ☐ Other _____
- ☐ 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

Gynecologic History

Date of Last Menstrual Period: _____
Date of Last Mammogram: _____

Obstetric History

Pregnancies: _____
Live Births: _____

Past Surgeries

Have you had any surgeries on the following organs?

- ☐ Abdominal Wall: Hernia Repair
- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Brain: (Cancer) (Trauma)
- ☐ Breast: Mastectomy (Right) (Left) (Both)
- ☐ Breast: Lumpectomy (Right) (Left) (Both)
- ☐ Breast: Breast Biopsy
- ☐ Cesarean Section
- ☐ Colon (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) (Left) (Both)
- ☐ Joint Replacement: Hip (Right) (Left) (Both)
- ☐ Other _____
- ☐ None
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Nephrectomy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Lung: Left (Lower) (Upper) Lobectomy
- ☐ Lung: (Right) (Left) Pneumonectomy
- ☐ Lung: Right (Lower) (Middle) (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)
- ☐ Uterus (Hysterectomy): (Fibroids) (Uterine Cancer)

Skin Disease History

Have you had any of the following skin conditions?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Other
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous cell skin cancer
- ☐ None

Do you wear Sunscreen? ○ Yes SPF? ___ ○ No

Do you tan in a tanning salon? ○ Yes ○ No

Family History

Do you have a family history of Melanoma? ◯ Yes ◯ No

If yes, which relative? _____

Plastic Surgery History

- ☐ Abdomen: Abdominal Wall Reconstruction
- ☐ Abdomen: Abdominoplasty
- ☐ Body Contouring: Brachioplasty
- ☐ Body Contouring: Liposuction
- ☐ Body Contouring: (Lower) (Upper) Body Lift
- ☐ Body Contouring: Thigh 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: (Lower) (Upper) Blepharoplasty
- ☐ Face: Mandible Fracture
- ☐ Face: Maxillary Fracture
- ☐ Face: Orbital Floor Fracture
- ☐ Face: Repair of Craniosynostosis
- ☐ Face: Zygoma Fracture
- ☐ Flap Reconstruction
- ☐ Hair Restoration
- ☐ Hand: Extensor Tendon Repair (Right) (Left)
- ☐ Hand: Flexor Tendon Repair (Right) (Left)
- ☐ Hand: Ganglion Cyst Removal
- ☐ Hand: Mallet Finger Repair (Right) (Left)
- ☐ Hand: Metacarpal Fracture Repair
- ☐ Hand: ORIF of Fracture (Right) (Left)
- ☐ Hand: Phalangeal Fracture Repair
- ☐ Hand: Trigger Finger Release (Right) (Left)
- ☐ Hand: Wrist Fracture Repair
- ☐ Laser Hair Removal
- ☐ Laser resurfacing - CO2
- ☐ Face: Front Orbital Advancement
- ☐ Face: Lefort Osteotomy
- ☐ Laser Resurfacing - Erbium
- ☐ Nose: (Rhinoplasty) (Septoplasty)
- ☐ Orthopedic Hardware Coverage
- ☐ Scar revision
- ☐ Skin Graft Reconstruction

- [ ] Face: (Cheek) (Chin) Augmentation
- [ ] Face: Facelift
- [ ] Face: Facial Fracture Repair
- [ ] Face: Facial Reanimation
- [ ] Face: Frontal Sinus Fracture
- [ ] Sternal Wound Reconstruction
- [ ] Tendon Transfer
- [ ] Vascular Graft Coverage
- [ ] Wound Reconstruction
- [ ] Other _____

Breast Cancer

Do you have a family history of breast cancer? ◯ Yes ◯ No
If so, which relative? _____

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? _____

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
- [ ] 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
- [ ] Other_____

_____
_____

Medications

List all current medications:

_____
_____
_____

Allergies

List all allergies and reactions if known:

_____
_____
_____

Social History

Social History Details

- ☐ Drug use
- ☐ IV Drug Use
- ☐ Other _____
- ☐ None
- ☐ Alcohol: less than 1 drink per day
- ☐ Alcohol: 1-2 drinks per day
- ☐ Alcohol: 3 or more drinks per day
- ☐ Alcohol: None

Smoking Status

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Smoker current status unknown
- ☐ If smoker, how many per day: _____

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never

How often do you exercise?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never