TUPELO PLASTIC SURGERY CLINIC

ROBERT C BUCKLEY MD

# Medical History Form

Date:_____
Name:_____
DOB:_____

Height:_____
Weight:_____
Age:_____

## Health History

Have you ever had or do you have any problems with:

| | Circle One | |
|---|---|---|
| Head | Yes | No |
| Eye | Yes | No |
| Ears, Nose, Throat | Yes | No |
| Thyroid | Yes | No |
| Lungs | Yes | No |
| Heart | Yes | No |
| High Blood Pressure | Yes | No |
| Stroke | Yes | No |
| Anemia | Yes | No |
| Blood Clots | Yes | No |
| Stomach | Yes | No |
| Bowels | Yes | No |
| Liver | Yes | No |
| Hepatitis | Yes | No |
| Jaundice | Yes | No |
| Muscles | Yes | No |
| Bones | Yes | No |
| Arthritis | Yes | No |
| Kidney or Bladder | Yes | No |
| Nervous System | Yes | No |
| Diabetes | Yes | No |
| Cancer | Yes | No |
| HIV | Yes | No |

If yes, explain in detail:_____
_____
_____
_____
_____
_____

Operations/Hospitalizations:_____
_____
_____
_____

## Current History

What problem brings you to our office today?_____
_____

What doctor do you see on a regular basis?_____
_____

Doctor(s) to whom you want records sent?_____
_____

## Medications

Allergic to medicine? Yes No
If yes, list medications:_____
_____
_____
_____
_____

List all medications you currently take:_____
_____
_____
_____
_____

Do you smoke? Yes No _____packs per day

Do you drink alcohol? Yes No

## Female Only

Are you pregnant? Yes No

Last menstrual period?_____

_____

**Signature of patient/guardian**