History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None

Other ______________________________

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Other ______________________________

Skin Disease History: (please circle all that apply)

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

Other ____

Do you wear Sunscreen? Yes No
If yes, what SPF? ________
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? ______________________________

Plastic Surgery History (please circle all that apply)

Abdomen
Abdominoplasty
Body Contouring: Brachioplasty
Body Contouring: Liposuction
Body Contouring: Lower Body Lift
Body Contouring: Thigh Lift
Body Contouring: Upper Body Lift
Breast: Breast Augmentation
Breast: Breast Lift (Mastopexy)
Breast: Breast Reconstruction
Breast: Breast Reduction
Cleft Lip Repair
Cleft Palate Repair
Ears: Ear
Face: Frontal Sinus Fracture
Face: Mandible Fracture
Face: Maxillary Fracture
Face: Orbital Floor Fracture
Face: Zygoma Fracture
Hand: Extensor Tendon Repair(s), Left Upper Extremity
Hand: Extensor Tendon Repair(s), Right Upper Extremity
Hand: Flexor Tendon Repair(s), Left Upper Extremity
Hand: Flexor Tendon Repair(s), Right Upper Extremity
Hand: Mallet Finger Repair, Left Upper Extremity
Hand: Mallet Finger Repair, Right Upper Extremity
Hand: Metacarpal Fracture Repair
Hand: ORIF of Fracture, Left Upper Extremity
Hand: ORIF of Fracture, Right Upper Extremity
Hand: Trigger Finger Release, Left Upper Extremity
Hand: Trigger Finger Release, Right Upper Extremity
Hand: Phalangeal Fracture Repair
Hand: Wrist Fracture Repair
Nose: Rhinoplasty
Nose: Septoplasty

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Abdominal Pain		
Anxiety		
Bleeding Problems		
Bloody Stool		
Bloody Urine		
Blurry Vision		
Changing Mole		
Chest Pain		
Cough		
Depression		
Fever or Chills		
Headaches		
Hay Fever		
Joint Aches		
Muscle Weakness		
Neck Stiffness		
Night Sweats		
Rash		
Seizures		
Shortness of Breath		
Sore Throat		
Thyroid Problems		
Unintentional Weight Loss		
Wheezing		

Other Symptoms: ______________________________

Cautions: (please circle all that apply)

Have you ever had difficulty-stopping bleeding?	Yes	No
Do you require antibiotics prior to a surgical procedure?	Yes	No
Have you had an artificial joint replacement?	Yes	No
If yes, when and what body locations? ______________________		
Do you have an artificial heart valve?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have a defibrillator?	Yes	No
Are you pregnant or currently trying to get pregnant?	Yes	No

Reconstruction
Ears: Otoplasty

Face:
Blepharoplasty
Face: Lower
Blepharoplasty
Face: Upper
Blepharoplasty
Face: Brow lift
Face: Facelift
Face: Facial
Fracture Repair

Medications: (Please enter all current medications)

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Allergies: (Please enter all allergies)

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Social History: (Please circle all that apply)

Currently Smokes
Has smoked in the past
Drug Use
None
Other____

Preferred Language: ______________________

Race and Ethnic Group:______________________