Plastic Surgery Patient Health History

Name: _____ Email: _____

Home Phone: _____ Work: _____ Cell: _____

Emergency Contact/Relationship: _____ Phone: _____

Primary Care Physician: _____ Swedish/Polyclinic/GH/Other: _____

Referring Physician: _____ Swedish/Polyclinic/GH/Other: _____

How did you hear about us? _____

Reason for coming in today: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Medical History: (Please check box below if you have any of the following symptoms or history of problems/diseases)

Anesthesia: □ **Difficult Airway** □ **ANY Problems with Anesthesia** _____

Head/Neck: □ Hearing Problems □ Eye Problems □ Nose/Sinus problems □ Dental (Dentures) □ Other: _____

Heart: □ h/o Heart Attack □ Chest Pain □ Irregular Heart Beat □ High Blood Pressure □ Other: _____

Lungs: □ Asthma □ COPD □ Sleep Apnea □ Shortness of Breath □ Chronic Cough □ Other: _____

Breast: □ Cancer (date diagnosed _____) Treatment/date: _____ □ Other: _____

GI: □ Reflux □ Ulcers □ Abdominal Pain □ Cancer (type) _____ □ Other: _____

Nervous System: □ Seizures □ Memory Loss □ Multiple Sclerosis □ Fibromyalgia □ Other: _____

Endocrine: □ Diabetes □ Thyroid disorder □ Other: _____

Hepato/Urinary: □ Kidney Problems □ Infections □ Hepatitis □ Other: _____

Psychological: □ Depression □ Bipolar Disorder □Anxiety □ Other: _____

Skin: □ Rashes □ Eczema □ Psoriasis □ Skin Cancer (type: _____) □ Botox □ Fillers □ Other: _____

Musculoskeletal: □ Arthritis □ Joint Problems □ Muscle Problems □ Other: _____

Hematology/Oncology: □ Blood Clotting Disorder □ Family History of Blood Clotting Disorder □ Factor V Leiden
□ Phlebitis □ Anemia □ HIV □ Lymphoma □ Leukemia □ Other: _____

Other Medical History: _____

ALLERGIES: _____

MEDICATIONS: _____
□ Oral Contraceptives □ Hormone Therapy □ NSAIDS □ Aspirin □ Plavix □ Coumadin □ Pradaxa □ Other Blood Thinners

Surgical History: (Check all that apply and explain w/ date)

□ Heart: _____ □ Lung: _____

□ Breast: _____ □ Gynecological: _____

□ Abdomen: _____ □ Orthopedic (bones): _____

□ Eyes: _____ □ Ear/Nose/Throat: _____

□ Cosmetic / Other: _____

Social History: Lives with: _____ Occupation/Employer: _____

□ Currently Smoking □ Past Smoker/Quit Date _____

□ Alcohol (_____ per week) □ Marijuana □ Other drugs _____

_____ _____ [Patient Label]
Signature of Patient or Legal Guardian Date