

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 _____

Signature of Patient or Legal Guardian

Date