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