

PAST MEDICAL HISTORY AND REVIEW OF SYMPTOMS

Primary Care Physician: _____
 Address: _____
 Phone: (_____) _____

Personal History

Birthplace:	Date of Birth:
Nationality:	Religion:
Marital Status:	Health of Spouse:
Education:	
Occupation(s):	
Residence past 5 years:	
Sleep (hours):	Aids to sleep:
Recreation:	
Exercise:	
Average per day (circle):	
Y N	Alcohol - Amount & Type:
Y N	Tobacco - Amount & Type:
Y N	Tea/Coffee - Amount & Type:

Medicines Taken Regularly	Reason	Dose/Frequency

Personal Past History (Circle YES or NO)

Have you ever had:	Year	Anesthesia Problems	Year
Whooping Cough	Y N	Malignant	Y N
Polio	Y N	Hyperthermia	Y N
Scarlet Fever	Y N	Troubles w/ tube placement	Y N
Diphtheria	Y N	Other (list) _____	
Meningitis	Y N		
Infectious Mono	Y N		
Valley Fever	Y N	Operations	
Tuberculosis	Y N	Facial	Y N
Exposure to TB	Y N	Appendix	Y N
Diabetes	Y N	Gallbladder	Y N
Hives	Y N	Stomach	Y N
Cancer	Y N	Breast	Y N
Venereal Disease	Y N	Uterus	Y N
Arthritis	Y N	Prostate	Y N
Back/Neck Trouble	Y N	Hernia	Y N
Bronchitis	Y N	Thyroid	Y N
Pneumonia	Y N	Varicose Veins	Y N
Pleurisy	Y N	Hemorrhoids	Y N
Asthma	Y N	Heart	Y N
Emphysema	Y N	Liposuction	Y N
Rheumatic Fever	Y N	Other (list) _____	
High Blood Pressure	Y N		
Heart Disease	Y N		
Blood Clots/DVT	Y N		
Pulmonary Embolism	Y N		
Anemia	Y N		
Bleeding/Transfusion	Y N	Injuries	
Hepatitis (yellow jaundice)	Y N	Head	Y N
Ulcer	Y N	Chest	Y N
Bladder Infections	Y N	Abdomen	Y N
Kidney Disease	Y N	Broken Bones	Y N
Hay Fever/Sinusitis	Y N	Back	Y N
Glaucoma	Y N	Other (list) _____	
Nose Bleeds	Y N		

Family History

Has any blood relative had any of the following (circle Yes or No. If Yes, what relationship?):

Anemia	Y N	_____
Bleeding Tendency	Y N	_____
Leukemia	Y N	_____
Blood Clots/DVT	Y N	_____
Pulmonary Embolism	Y N	_____
Repeated Infections	Y N	_____
Crippling Infections	Y N	_____
Heart Disease	Y N	_____
Chronic Lung Disease	Y N	_____
Tuberculosis	Y N	_____
High Blood Pressure	Y N	_____
Kidney Disease	Y N	_____
Asthma	Y N	_____
Severe Allergies	Y N	_____
Mental Illness	Y N	_____
Convulsions or fits	Y N	_____
Migraine Headaches	Y N	_____
Diabetes	Y N	_____
Obesity	Y N	_____
Thyroid Trouble	Y N	_____
Peptic Ulcer	Y N	_____
Cancer	Y N	_____
Malignant Hyperthermia	Y N	_____

	Present Age or Age at Death	If living, Health (Good, Fair, Poor). If deceased, cause of death.
Father		
Mother		
Brothers/Sisters		
1.		
2.		
3.		
4.		
5.		
6.		
7.		
Children		
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Allergies	Immunizations
Are you allergic to:	Small Pox
Tetanus Antitoxin	Tetanus
Penicillin	Polio Shots
Sulfa	Polio Oral
Latex	Hepatitis
Other drugs (list)	Other (list)
_____	_____
_____	_____
_____	_____
Foods	Y N
Cosmetics	Y N
Other	Y N

PLEASE TURN OVER THIS PAGE. FILL OUT BOTH SIDES OF THIS FORM.

PLASTIC SURGERY SPECIALISTS <input type="checkbox"/> Robert A. Hardesty, M.D., F.A.C.S. <input type="checkbox"/> Della C. Bennett, M.D. <input type="checkbox"/> Leah R. Zalsman, PA-C	Patient Name: _____ DOB: _____ MR# _____ Date of Service: _____
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