PLASTIC SURGERY SPECIALISTS, P.C.
MEDICAL HISTORY

Date: _____

Name: _____ Age: _____ HT: _____ WT: _____

Primary MD: _____ Referring MD: _____

Reason for Office Visit: _____

Please Circle If You Have A History Of:

Asthma	Emplysema	Colon Disease	High Blood Pressure	Tuberculosis
Diabetes	Epilepsy	Cancer	Abnormal Bleeding/Bruising	Glasses/Contact Lenses
Depression	Stroke	Kidney Disease	Anesthesia Difficulty	Dental Appliances
Heart Attack	Irregular Heart Beat		Heart Valve Disease	Chest Pain
Difficulty Climbing Stairs		Heart Failure	Pacemaker	Heart Surgery
Difficulty Lying Flat		Other Medical Problem		

Describe: _____

_____

Do You Smoke? ☐ Yes ☐ No _____ packs per day _____
Office comment

Drug Allergies and Your Reaction: _____

Other Allergies: Food _____ Latex _____ Other _____

Medications and Reason For Taking: (No Dosage Necessary)

_____

_____

_____

Prior Surgeries: _____

_____

Females, Please Complete:

Last Menstrual Period: _____ Pregnant? ☐ Yes ☐ No

Date of Last Mammogram: _____ #Children _____