LAKEVIEW Plastic Surgery
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# Medical History Form

**Patient Name:** _____ **Date of Birth:** _____

**Today's Date:**_____ **Current weight:** _____
**Current height:** _____

**Reason for Visit:** _____

**How Did You Hear About Us?** ❑ Doctor Referral ❑ Internet ❑ Friend Referral ❑ Social Media (e.g., Yelp)
❑ Other _____

**SOCIAL HISTORY**

| | | | |
|---|---|---|---|
| Do you smoke? | Yes | No | If yes, how many packs per day? _____ |
| Have you ever smoked? | Yes | No | For how many years? _____ |
| Do you use any street drugs? | Yes | No | |
| Do you drink alcohol? | Yes | No | If yes, how many drinks (average) per week? _____ |
| Do you exercise regularly? | Yes | No | If yes, how many times (average) per week? _____ |

**PHARMACY INFORMATION**
Pharmacy Name: _____ Tel: _____
Address: _____

**MEDICATIONS AND SUPPLEMENTS**
Please list all medications and supplements you are currently taking.

| Name of Medication | Dose and Frequency | Reason for taking |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Do you take any blood thinners?**
___ No ___ Coumadin ___ Aspirin ___ Other: _____

**ALLERGIES**
_____ I have no known allergies
_____ I have the following allergies:

| Medication/Substance | Reaction |
|---|---|
| | |
| | |

**FAMILY HISTORY**
Does or did anyone in your family have any of the following conditions?

| Condition | Relationship | Description |
|---|---|---|
| ❑ Cancer | | |
| ❑ Bleeding or clotting disorders | | |
| ❑ Diabetes | | |
| ❑ Heart attack | | |
| ❑ Stroke | | |
| ❑ Other | | |

**(Please turn to other side.)**

**MEDICAL HISTORY**

Are you currently having any problems or conditions related to the following?

**Constitutional**

| | | | |
|---|---|---|---|
| Fevers | Yes | No | In the Past |
| Chills | Yes | No | In the Past |
| Weight gain/loss | Yes | No | In the Past |
| Excessive fatigue | Yes | No | In the Past |
| Ongoing Infection | Yes | No | |

**Endocrine**

| | | | |
|---|---|---|---|
| Diabetes/High blood sugar | Yes | No | In the Past |
| Thyroid problems | Yes | No | In the Past |
| Excessive Thirst | Yes | No | In the Past |

**Cardiovascular**

| | | | |
|---|---|---|---|
| Chest pain (angina) | Yes | No | In the Past |
| Heart failure (CHF) | Yes | No | In the Past |
| Irregular heartbeat | Yes | No | In the Past |
| High blood pressure | Yes | No | In the Past |
| Low blood pressure | Yes | No | In the Past |
| Blood clots (DVT or PE) | Yes | No | In the Past |
| Bleeding disorders | Yes | No | In the Past |

**Respiratory**

| | | | |
|---|---|---|---|
| Wheezing | Yes | No | In the Past |
| Coughing | Yes | No | In the Past |
| Shortness of breath | Yes | No | In the Past |

**Breast**

| | | | |
|---|---|---|---|
| Breast pain | Yes | No | In the Past |
| Nipple discharge | Yes | No | In the Past |
| Breast lumps or masses | Yes | No | In the Past |
| Abnormal mammogram | Yes | No | In the Past |

**Neurological**

| | | | |
|---|---|---|---|
| Headaches | Yes | No | In the Past |
| Dizzy spells | Yes | No | In the Past |
| Numbness/Tingling | Yes | No | In the Past |

**Eyes**

| | | | |
|---|---|---|---|
| Blurred vision | Yes | No | In the Past |
| Double vision | Yes | No | In the Past |

**Gastrointestinal**

| | | | |
|---|---|---|---|
| Abdominal pain | Yes | No | In the Past |
| Heartburn/indigestion | Yes | No | In the Past |
| Abnormal bowel mvmts | Yes | No | In the Past |

**Integument (Skin)**

| | | | |
|---|---|---|---|
| Rashes | Yes | No | In the Past |
| Acne | Yes | No | In the Past |
| Persistent itching | Yes | No | In the Past |
| Psoriasis | Yes | No | In the Past |

**Psychologic**

| | | | |
|---|---|---|---|
| Depression | Yes | No | In the Past |
| Suicidal thoughts | Yes | No | In the Past |

**Genitourinary**

| | | | |
|---|---|---|---|
| Urinary frequency | Yes | No | In the Past |
| Urinary retention | Yes | No | In the Past |
| Painful urination | Yes | No | In the Past |
| Unusual vaginal discharge | Yes | No | In the Past |
| Unusual vaginal bleeding | Yes | No | In the Past |

| Medical Conditions | Medical Conditions |
|---|---|
| | |
| | |
| | |
| | |

| Surgery/Procedure | Date | Reason for surgery |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Have you ever had a complication related to anesthesia?** Yes No

**If yes, please describe:**_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

**SIGNATURE OF PATIENT, PARENT or GUARDIAN:** _____ **DATE:** _____