



Kaufman & Clark Plastic Surgery

Date _____

Patient _____ Chart # _____

Date of Birth ____/____/____ Age _____

MEDICAL HISTORY

Please Print

PLEASE FILL OUT THE FOLLOWING INFORMATION COMPLETELY. IF YOU ARE UNSURE OF ANY INFORMATION REQUESTED, PLEASE BE SURE TO ASK YOUR PHYSICIAN AT THE TIME OF YOUR APPOINTMENT. PLEASE RESPOND TO EACH STATEMENT AND ANSWER "N/A" IF APPROPRIATE. THANK YOU!

Height _____ Weight _____

Vision: Do you wear glasses? ____ Yes ____ No Contacts? ____ Yes ____ No

Are you legally blind? ____ Yes ____ No ____ Rt. Eye ____ Left Eye ____ Both Eyes

Are you ALLERGIC to any MEDICATIONS and/or FOODS? ____ Yes ____ No If yes, please explain below.

Are you currently taking any MEDICATION? ____ Yes ____ No If yes, please list below.

Are you allergic to LATEX? ____ Yes ____ No If yes, have you been tested ____ Yes ____ No

Are you currently taking any medication that contains aspirin? ____ Yes ____ No If so, please circle any in this following list~Aspirin~Bayer~Excedrin~Ibuprofen~Advil~Neprin~Motrin or any other medication for Arthritis or Other: _____

Prior Surgeries? ____ Yes ____ No If Yes, Please list: _____

Any Complications with Anesthesia? ____ Yes ____ No

Any significant illness as a child? ____ Yes ____ No

If Yes, Please explain: _____

Any significant illness as an adult? ____ Yes ____ No

If Yes, Please explain: _____

Any significant illness in your family? ____ Yes ____ No

If Yes, Please explain: _____

Do you smoke? ____ Yes ____ No If yes, how much per day? _____

Do you drink alcohol? ____ Yes ____ No If yes, How much per week? _____

PLEASE TURN THIS PAGE OVER AND COMPLETE THE MEDICAL INFORMATION



**Kaufman & Clark
Plastic Surgery**

PLEASE CIRCLE THE APPROPRIATE RESPONSE Y-YES N-NO U-UNSURE

AIRWAY

Capped, chipped, broken teeth Y N U
 Difficulty opening your mouth fully Y N U

RESPIRATORY

Used tobacco within the year Y N U
 Persistent cough Y N U
 Sputum, phlegm, mucus production Y N U
 Asthma, wheezing Y N U
 Bronchitis, Emphysema, COPD
 Tuberculosis Y N U
 Shortness of breath after walking two
 Flights of stairs Y N U
 Recent cold Y N U
 Do you use a breathing device Y N U
 If yes, can you bring it with you that
 Day of surgery? Y N U

HEART

Chest pain, angina, MI, heart attack Y N U
 Leg swelling, edema, CHF Y N U
 Paralysis Y N U
 High blood pressure Y N U
 Heart murmur, prolapsed mitral valve,
 Rheumatic fever Y N U
 Leg cramps when walking Y N U

SKIN

Problems with wounds healing Y N U
 Scar badly Y N U
 Bruise easily, excessive bleeding Y N U
 Allergic reaction to adhesive tape Y N U

ENDOCRINE

Diabetes, if yes will you need and insulin
 Order from your doctor Y N U
 Thyroid problems, heat or cold
 Intolerance Y N U
 Low blood sugar Y N U

ABDMEN

Hiatal hernia, frequent
 regurgitation, heartburn Y N U
 Ulcers, vomiting blood
 hepatitis, jaundice Y N U
 Liver disease, cirrhosis Y N U
 Kidney disease Y N U

GENITOURINARY

Could you be pregnant Y N U
 Difficulty passing urine Y N U
 At risk for AIDS or venereal
 diseases Y N U

MUSCULOSKELETAL

Physical limitations, appliances, or
 prosthesis Y N U
 Arthritis (jaw, neck, back) Y N U
 Phlebitis Y N U

NEUROLOGICAL/PSYCHIATRIC

Seizures, convulsions, fainting,
 epilepsy Y N U
 Stroke, fleeting blindness or
 weakness Y N U
 Psychiatric treatment Y N U
 Anxious about possible surgery Y N U

GENERAL

Headaches, unexplained
 weight loss Y N U
 Steroid use within 1 yr. Y N U
 Blood transfusion Y N U
 Have used recreation drugs Y N U
 Anemia or bleeding disorder Y N U
 Glaucoma Y N U
 Chemotherapy(w/in 6 months) Y N U

If you answered YES to any of the above, please explain:
