Clinton Plastic Surgery Center **PATIENT MEDICAL HISTORY**

(This information is protected by the Health Insurance Portability and Accountability Act)

Name: ______________________ **Age:** __________ **Sex:** ☐ **M** ☐ **F**

Reason For Visit: ______________________ **Ht:** __________ **Wt:** __________

Daily Medications: **(Name and Dosage; please include vitamins, nutritional supplements, diet pills, and chronic steroid use such as Prednisone)**

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Drug Allergies: Name & Type of Reaction; ______________________

______________________ **If Allergic to Penicillin, can you take Keflex?** __________

Previous Surgery (Type & Date): ______________________

______________________ **Have you had any abdominal surgeries? YES / NO**

PAST MEDICAL HISTORY: Please check YES or NO	**Yourself**		**Family Members**		**Relationship**
Heart Disease (heart attack, heart failure abnormal rhythm)	yes ____	no ____	yes ____	no ____	________
Mitral Valve Prolapse	yes ____	no ____	yes ____	no ____	________
Asthma	yes ____	no ____	yes ____	no ____	________
Diabetes	yes ____	no ____	yes ____	no ____	________
Hypertension (high blood pressure)	yes ____	no ____	yes ____	no ____	________
Hepatitis	yes ____	no ____	yes ____	no ____	________
Jaundice	yes ____	no ____	yes ____	no ____	________
Malignant Hyperthermia	yes ____	no ____	yes ____	no ____	________
Seizures	yes ____	no ____	yes ____	no ____	________
Bleeding Tendency	yes ____	no ____	yes ____	no ____	________
Deep Vein Thrombosis	yes ____	no ____	yes ____	no ____	________
Pulmonary Embolism	yes ____	no ____	yes ____	no ____	________
Glaucoma	yes ____	no ____	yes ____	no ____	________
Cancer	yes ____	no ____	yes ____	no ____	________
Adverse Reaction to Anesthesia (if yes, give details)	yes ____	no ____	yes ____	no ____	________

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Please list any other illness that required surgery, hospitalization or chronic treatment: ______________________

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FOR WOMEN ONLY:

Breast Cancer History: Self? __________ **Mother or Sister?** __________

Pregnancies: How many ______ **Type of delivery** __________ **Ages of children** __________

If considering breast surgery: Current Bra size __________ **Desired size** __________

Date of last Mammogram __________ **Results** __________

Do you smoke? Yes / No If yes, how many cigarettes per day? __________ Would you be willing to stop smoking for a period of two weeks prior and three weeks after your surgery? Yes / No

Do you drink alcoholic beverages? Yes / No If yes, how much? __________

Do you have a history of drug or alcohol abuse? If yes, please describe: __________

I attest that the information I have provided above is correct, complete and current, realizing that the medical care provided to me may be based on this information. ______________________ **Date:** __________

Signature Required