PLASTIC SURGERY CENTER OF VIRGINIA
MEDICAL HISTORY

Patient Name: _____ Date: _____

Height: _____ Weight: _____ Occupation: _____

Family Physician: _____ Referring Physician: _____

***Check any past or current medical problems.***

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Sickle cell trait/disease
- ☐ Heartburn/GERD/ulcers
- ☐ Congestive Heart Failure
- ☐ Frequent Bladder Infections
- ☐ Hepatitis A B or C
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Alcoholism/Drug Dependency
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Excessive bleeding problems
- ☐ Blood clots (legs/lung)
- ☐ Cancer _____
- ☐ Stroke/Ministroke
- ☐ Kidney Disease/Failure
- ☐ HIV or AIDS
- ☐ Osteoporosis
- ☐ Liver Disease
- ☐ Epilepsy/Seizures
- ☐ Adverse reaction to anesthetic (local or general)
- ☐ Angina
- ☐ Heart attack
- ☐ Heart arrhythmia
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ High Cholesterol
- ☐ Thyroid Problems
- ☐ Fibromyalgia
- ☐ Depression/Anxiety
- ☐ Alzheimer's Disease

Do you have any other medical problems or conditions? ☐ YES ☐ NO
If YES, please list: _____

Does any relative have the same medical condition(s)? ☐ YES ☐ NO
If YES, who? _____

List previous surgeries (including cosmetic surgery) with dates. _____

_____

List any complication with surgery or anesthesia: _____

_____

List any ALLERGY to medications including local anesthesia and reaction: _____

_____

Do you use tobacco? ☐ YES ☐ NO If YES: What type: _____ How long: _____
How much per week: _____

If NO: Have you ever smoked? ☐ YES ☐ NO When did you quit? _____

Do you drink alcohol? ☐ YES ☐ NO If YES: What type: _____
How much per week _____

Do you exercise regularly? ☐ YES ☐ NO If YES: How often per week _____

NAME: _____ CHART NUMBER: _____

Do you have a history of connective tissue disorder? □ YES □ NO
When was your last tetanus shot? _____

Do you take blood thinner, aspirin, baby aspirin or Vitamin E? □ YES □ NO
If YES: List medicine, dose and frequency: _____

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**FOR WOMEN ONLY**

Do you think you are pregnant? □ YES □ NO

When was the date of your last menustrual period? _____

Do you have children? □ YES □ NO If YES: Number of pregnancies: _____

Number of living children: _____

Have you ever had a mammogram? □YES □ NO IF YES: Date of Last_____
Result: _____

Family history of breast cancer? □ YES □ NO If YES: Who: _____

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## CURRENT MEDICATIONS

***Please list ALL current medications you are taking. This includes prescription medicine, over-the-counter medicine, herbal supplements and homeopathic remedies.***

| NAME | DOSE | FREQUENCY |
|---|---|---|
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## PREVIOUS MEDICATIONS

*Please list ALL medications you have used and stopped within the last six months. This includes prescription medicine, over-the-counter medicine, herbal supplements and homeopathic remedies.*

| NAME | DOSE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

NAME: _____ CHART NUMBER: _____

# REVIEW OF SYSTEMS

Have you experienced any of these recently? Check all that apply.

**MUSCULOSKELETAL**

- ☐ Multiple joint pain/stiffness
- ☐ Frequent back/neck pain
- ☐ Hot or swollen joints
- ☐ Increasing muscle weakness

## GENERAL

- ☐ Gained/Lost weight recently
- ☐ Significant decrease in general energy level recently
- ☐ High fever/shaking/chills/night sweats

## HEAD AND NECK

- ☐ Unusual headaches
- ☐ Sudden change in vision
- ☐ Difficulty swallowing hard/dry food
- ☐ Frequent dizziness on standing
- ☐ Recent change in hearing
- ☐ Recent change in voice

## HEART AND LUNGS

- ☐ Pain/heaviness in your chest
- ☐ Short of breath with mild exertion
- ☐ Wheezing
- ☐ "Fluttering" of your heart
- ☐ Can't breathe at night/need extra pillows
- ☐ Persistent Cough

## ABDOMEN

- ☐ Unexplained pain
- ☐ Bleeding from bowels
- ☐ Change in bowel habits (recent constipation or diarrhea)
- ☐ Vomiting Blood
- ☐ Persistent nausea or vomiting

## BLADDER AND KIDNEYS

- ☐ Recent pain/burning when urinating
- ☐ Urinating more frequently at night
- ☐ Post menopausal
- ☐ Loss of urine with cough/sneeze
- ☐ Blood in urine
- ☐ Unusually painful or heavy menstrual periods

## SKIN AND HAIR

- ☐ Sudden/unexpected loss of hair
- ☐ Recent changes in sizes/colors of moles
- ☐ Recent skin rashes
- ☐ Excessive bruising

## BRAIN AND NERVES

- ☐ Recent loss of memory
- ☐ Persistent numbness or tingling
- ☐ Unusual smells or tastes
- ☐ Clumsiness/Weakness in arms or legs
- ☐ Recent shaking/tremor in hands

## MENTAL HEALTH

- ☐ Difficulty controlling temper
- ☐ Recent trouble sleeping
- ☐ Feeling depressed recently
- ☐ Recent loss of a loved one
- ☐ Usually take sleeping pills
- ☐ Often take nerve pills/tranquilizers

Over the past two weeks have you felt down, depressed or hopeless? ☐ YES ☐ NO
Over the past two weeks have you felt little interest or pleasure in doing things? ☐ YES ☐ NO