Medical History Questionnaire

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Plastic and Reconstructive Surgery

Past Medical History

Do you or have you had:

	Yes	No		Yes	No
Prolonged bleeding when cut	❑	❑	Fainting or blackout episodes	❑	❑
High blood pressure	❑	❑	Ulcer disease	❑	❑
Heart disease or attack	❑	❑	Hepatitis	❑	❑
Heart murmur or disorder	❑	❑	Blood transfusions	❑	❑
Chest pain or shortness of breath	❑	❑	Reactions to blood transfusions	❑	❑
Excessive or unsatisfactory scar formation	❑	❑	Other significant illness If so, please describe _____	❑	❑
Aspirin intake in the past two weeks (Avoid aspirin for two weeks prior to surgery)	❑	❑			

Previous operations: Date

_____ _____

_____ _____

Please list any medications you are allergic to: Reaction

_____ _____

_____ _____

Please list **ALL** medications that you are currently taking (include dosage and frequency):

_____ _____ _____

_____ _____ _____

Personal/regular physician:

Name: _____ Specialty: _____

Address: _____
Street City State Zip

Telephone: _____ Date of last exam: _____ Results: _____

Family History

Is there a history of the following in your immediate family? If so, please list the family member beside the disease.

		Yes	No			Yes	No
High blood pressure	_____	❑	❑	Heart disease	_____	❑	❑
Diabetes	_____	❑	❑	Cancer	_____	❑	❑
Hepatitis	_____	❑	❑	Type	_____		
Stroke	_____	❑	❑				

Personal History

Occupation: _____
Do you smoke? ❑ No ❑ Yes _____ packs per day
Do you drink alcohol? ❑ No ❑ Occasionally ❑ Regularly _____ per day
Do you use any other drugs or medications not listed above? ❑ No ❑ Yes If yes, please list: _____