



ATLANTA PLASTIC SURGERY, P.C.

Date _____

Patient Medical History

CONFIDENTIAL INFORMATION: Information contained herein will not be released except when you have authorized us to do so. Please answer **all** questions to the best of your knowledge. The information that you provide will be used by your doctor in his decisions regarding your care.

Patient Information

Patient's Name _____ Last _____ First _____ Middle _____ DOB ____/____/____ Age _____

Ht. _____ Wt. _____ Sex M F Single Married Widowed Divorced

Physician Information

Referring Physician: _____ Address: _____

Family Physician: _____ Address: _____

Oncologist: _____ Address: _____

Pediatrician: _____ Address: _____

Send correspondence to: _____ Address: _____

Last physical exam M.D.: _____ Date of Last Physical Exam: _____

Medical Information Do you have or have you had: (circle - if yes, give date of occurrence)

AIDS or HIV +	No Yes _____	Congenital Heart	No Yes _____	Leukemia	No Yes _____
Arthritis	No Yes _____	Diabetes	No Yes _____	Migraine	No Yes _____
Asthma	No Yes _____	Epilepsy	No Yes _____	Nervous Breakdown	No Yes _____
Back Problems	No Yes _____	Goiter	No Yes _____	Pneumonia	No Yes _____
Bladder Infection	No Yes _____	Hay Fever	No Yes _____	Rheumatic Heart	No Yes _____
Bleeding Tendency	No Yes _____	Heart Attack	No Yes _____	Stomach Ulcers	No Yes _____
Bronchitis	No Yes _____	Hepatitis	No Yes _____	Stroke	No Yes _____
Cancer	No Yes _____	High Blood Pressure	No Yes _____	Tonsilitis	No Yes _____
Colitis	No Yes _____	Kidney Disease	No Yes _____	Tuberculosis	No Yes _____

Other serious illnesses that you have had: _____

Do you regularly smoke? Y N How much? _____ Do you regularly drink 6 or more cups of coffee per day Y N

Do you regularly drink alcohol or beer? Y N How much? _____ Date of last chest x-ray: _____

Are you presently taking any of the following medications? (circle)

Antibiotics	Cortisone	Insulin or diabetic pills	Sleeping pills
Aspirin, Bufferin, Anacin	Cough medicine	Iron or poor blood medication	Thyroid medicine
Barbituates	Digitalis	Laxatives	Tranquilizers
Birth control pills	Dilantin	Medicine for arthritis	Water pills
Blood pressure pills	Headache pills	Phenobarbital	Weight-reducing pills
Blood-thinning pills	Hormones	Shots	Other drugs not listed

Do you know of any blood relative who has or had: (circle and give relationship)

Arthritis	_____	Epilepsy	_____	Mental Illness	_____
Asthma	_____	Goiter	_____	Migraine	_____
Bleeding tendency	_____	Hay fever	_____	Nervous breakdown	_____
Breast cancer	_____	Heart attack	_____	Rheumatic heart	_____
Other cancer	_____	High blood pressure	_____	Stomach ulcers	_____
Colitis	_____	High fever after surgery	_____	Stroke	_____
Congenital heart disease	_____	Kidney disease	_____	Suicide	_____
Diabetes	_____	Leukemia	_____	Tuberculosis	_____

Medical Information (continued)

Please list any medications (prescription or over-the-counter) that you have taken within the last month.

Please specify: _____

Are you presently on or have you taken any diet or appetite suppressant pills in the last six months. Please list:

Please list the names and year of any operations you have ever had:

Name any drugs to which you are allergic:

Serious injuries or accidents

Have you ever had any complications from anesthesia? Y N

Explain: _____

Do you frequently have bleeding gums? Y N

Do you have nose bleeds? Y N

How often? _____

Have you ever bled excessively from a tooth extraction? Y N

Do you bleed excessively from a laceration? Y N

Do you take aspirin regularly? Y N

How often? _____

If yes, stop taking them until after your surgery

Have you had blood transfusions? Y N

Any adverse reactions? _____

Women Only

Is there any chance you may be pregnant? Y N

Are you still having regular monthly menstrual periods? Y N

Date of last menstrual period: _____

Date of last mammogram: _____

Results: _____

How many children? _____

We recommend routine breast and pelvic exams by your physician for all adult females.

Office Use Only

B/P _____ P _____ R _____ T _____

Pre-Operative Photos? Y N Taken by: _____

Laboratory tests completed? Y N

Instructions / orders to patient: _____

Comments: _____

Surgery: Date: _____ Time: _____ Location: _____