CHARLOTTE
PLASTIC SURGERY.

MEDICAL HISTORY FORM

Medical History

Patient's Name: _____ Date: _____

D.O.B _____ Age: _____ Height: _____ Weight: _____ BMI: _____

Blood Pressure _____/_____ Pulse _____
(will be taken in exam)

Date of last physical exam: _____

Did it include an electrocardiogram?
Yes / No
Date? _____

Mammogram?
Yes / No
Date?_____

Chest X-ray?
Yes / No
Date?_____

Doctor Name & Address: _____

Medications, Drugs

Are you allergic to any medicines?	Yes / No	If yes, which one(s)? _____
Do you have any food allergies? Yes / No	Yes / No	If yes, which one(s)? _____
Are you allergic or sensitive to *Latex?*	Yes / No	

Please list all medications you are now taking and their dosages, including: birth control pills, IUD, diuretics (water pills), blood pressure, or heart medications, tranquilizers, hormones, blood thinners, aspirin, etc.

List any over-the-counter medications, herbal remedies, and vitamins you currently take:

PREVIOUS SURGERY (Please list)

Operation	Year	Hospital	City	Surgeon	Anesthesia Local or general

PAST OR CURRENT MEDICAL HISTORY *DIAGNOSIS* (Please list)
Are you Pregnant? Yes/no

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Social History

What is your daily consumption of the following? Coffee or Tea_____ Alcohol_____

Marijuana ☐ Yes ☐ No
How often? _____

Tobacco / nicotine /
Vaping _____

Mind altering Drugs
(please specify): _____

Family History

	Age	State of Health
Mother		
Father		
Sister(s)		
Brother(s)		
Children		

Has any relative had:	
Breast Cancer History	Yes/No Who? _____
Asthma.	Yes/No Who? _____
Blood or Bleeding Disorders	Yes/No Who? _____
Cancer.	Yes/No Who? _____
Heart Disease	Yes/No Who? _____
High Blood Pressure	Yes/No Who? _____
Lung Disease	Yes/No Who? _____
Kidney Disease	Yes/No Who? _____
Tuberculosis.	Yes/No Who? _____
Epilepsy.	Yes/No Who? _____
Mental Disease	Yes/No Who? _____

Have you required unusually large amounts of local anesthetic for medical or dental procedures?	No ___ Yes ___
Have you ever had a bad reaction to a local anesthetic (Novocain, etc)?	No ___ Yes ___
Do you have family or personal history of anesthesia complications?	No ___ Yes ___
Are you allergic to adhesive tape?	No ___ Yes ___
Have you ever had Scarlet Fever or Rheumatic Fever?	No ___ Yes ___
Do you have shortness of breath with walking?	No ___ Yes ___
Do you bleed unusually easily (from cuts, surgery, tooth extractions)?	No ___ Yes ___
Are you a slow or poor healer?	No ___ Yes ___
Do you form large scars or keloids?	No ___ Yes ___
Do you have any skin disease, hives, eczema or rash?	No ___ Yes ___
Do you have frequent infections or boils?	No ___ Yes ___
Have you taken steroid medications, cortisone, or ACTH?	No ___ Yes ___
Have you required a transfusion for surgery?	No ___ Yes ___
Does your religion prohibit blood transfusions?	No ___ Yes ___
Do you have, or have you had, any significant emotional problems?	No ___ Yes ___
Have you ever had psychiatric care?	No ___ Yes ___
Have you ever been advised to see a psychiatrist?	No ___ Yes ___
Do you have sleep apnea?	No ___ Yes ___
Do you have high blood pressure?	No ___ Yes ___
Do you have diabetes?	No ___ Yes ___
Do you have Hepatitis?	No ___ Yes ___
Do you have HIV / AIDS?	No ___ Yes ___
Do you have family or personal history of DVT?	No ___ Yes ___

Signature: _____ Date: _____