INFORMATION FOR CASE HISTORY FILE

(PLEASE complete all items, PLEASE print or type)

Today's Date_____

Patient's Name_____ **Referred By**_____
(First) (Last)

Mrs. ❑ Miss ❑ Mr. ❑ Ms. ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑

Age_____ **Date of Birth**_____ **SS#**_____

Home Address_____ **City**_____ **State**____ **Zip**_____

Home Phone_____ **Cell Phone**_____ **Email**_____

Patient's Occupation_____ **Employer**_____

Business Address_____**Business Phone**_____**Ext.**_____

Name of Spouse_____**Spouse's Occupation**_____

Spouse's Employer_____ **Address**_____ **Business Phone**_____

Family Doctor_____ **Address**_____ **Phone**_____

Emergency Contact_____**Phone No.**_____**Pharmacy Phone**_____

Insurance Company_____ **Group No.**_____ **Policy No.**_____

Address of Insurance Co._____

Through what Company or Employer?_____

SS# of Card Holder_____ **Group No.**_____ **Birth Date of Card Holder**_____

If person completing form is someone other than patient, or if the patient is a minor, please complete the following:

Name_____ **Relationship**_____
(Party financially responsible)

Address_____
(Street) (City) (State) (Zip)

Occupation_____**Employer**_____

Business Address_____**Business Phone**_____

Specific problem(s) for which you are seeking plastic surgery:_____

Have you consulted any other doctors, including plastic surgeons, about this? No_____ **Yes**_____

If yes, please list their name(s)_____

Release of Information

May we leave a message at your home with other residents? Yes_____ **No**_____

May we leave a message on your home answering machine? Yes_____ **No**_____

May we leave a message on your cell phone voice mail? Yes_____ **No**_____

With whom may we speak about your medical concerns?

Name:_____ **Relationship:**_____ **Phone No.**_____

Is this contact for emergencies only? Yes_____ **No**_____

Can they be contacted about your general care? Yes_____ **No**_____

Allergies

Are you allergic to any medications? ☐ **No** ☐ **Yes**

If "Yes," which one(s)?_____

MEDICATIONS

Please list all medications taken within the last *one year* and their dosages (including VITAMINS, BIRTH CONTROL PILLS, DIURETICS (water pills), BLOOD PRESSURE MEDICATIONS, TRANQUILIZERS, HORMONES, BLOOD THINNERS, NOSE DROPS and SPRAYS, EYE DROPS, INHALER MEDICINES, RUB-ON MEDICATIONS (liniments), ASPIRIN, BUFFERIN, ETC.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

PAST MEDICAL HISTORY

General Health: ☐ **Good** ☐ **Fair** ☐ **Poor**

If not "Good," please explain:

_____

Height_____ **Weight**_____ **Weight loss or gain in past year?**_____**lbs.** ☐ **Loss** ☐ **Gain**

How long ago was your most recent physical check-up?_____

Name and address of the doctor_____
(Name) (Address)

Did it include an electrocardiogram (EKG)? ☐ **No** ☐ **Yes** **Did it include a chest x-ray?** ☐ **No** ☐ **Yes**

When was your last menstrual period? _____

Past Surgical History (Please List all surgeries *including cosmetic*)

Operation	Year	Facility	City	Surgeon's Name	Anesthesia (Local or General)

Have you had significant complications or aftereffects from any of these operations? ☐ **No** ☐ **Yes**
If "Yes,"
Please explain:_____

_____

Have you ever undergone Laser or Radiation Therapy? ☐ **No** ☐ **Yes** **If "Yes" to what part(s) of your body and when?**

_____

Have You Had, Or Do You Still Have:

Cold or a Cough within the last two weeks……☐ No ☐ Yes

Breathing Problems (Asthma, Shortness of Breath with walking, etc)……☐ No ☐ Yes

Chest Pain or Angina……☐ No ☐ Yes

Heart Problems……☐ No ☐ Yes

Palpitations, Irregular or Fast Heart Beat……☐ No ☐ Yes

High Blood Pressure……☐ No ☐ Yes

Problems with Circulation……☐ No ☐ Yes

Blood Diseases (Anemia, etc)……☐ No ☐ Yes

Bleeding Problems……☐ No ☐ Yes

Deep Vein Thrombosis (Blood Clot)……☐ No ☐ Yes

Immune Problems or Diseases (HIV, etc)……☐ No ☐ Yes

Liver Disease (Hepatitis, Jaundice)……☐ No ☐ Yes

Stomach Problems (Ulcer, Reflux, etc)……☐ No ☐ Yes

Intestinal Problems (Irritable Bowel Syndrome, etc)……☐ No ☐ Yes

Neck or Back Pain……☐ No ☐ Yes

Seizures……☐ No ☐ Yes

Headaches……☐ No ☐ Yes

Stroke or Temporary Paralysis……☐ No ☐ Yes

Psychiatric or Psychological Treatment……☐ No ☐ Yes

Any Visual or Eye Problems (Glaucoma, Dry Eyes, etc)……☐ No ☐ Yes

Glasses or Contact Lenses……☐ No ☐ Yes

Diabetes……☐ No ☐ Yes

Thyroid Problems……☐ No ☐ Yes

Kidney or Bladder Problems……☐ No ☐ Yes

Any Problems During Pregnancy……☐ No ☐ Yes

Problems with Alcohol or Drug Abuse……☐ No ☐ Yes

Autoimmune Diseases (Lupus, Rheumatoid Arthritis, Scleroderma, etc)……☐ No ☐ Yes

Cold Sores or other Herpes Infections……☐ No ☐ Yes

Change in any skin growth (Moles, etc)……☐ No ☐ Yes

Cancer of any type……☐ No ☐ Yes

Serious Illnesses Not Mentioned Above (Please List)

_____

_____

INJURIES

Type of Injury **Year** **Hospital** **Doctor** **After-Effects**

_____

_____

SOCIAL HISTORY

Smoker: Yes ● No ● _____ # of times per day for _____# of years. If you quit, how long ago?_____

Are there other smokers in the house? Yes ☐ No ☐ How many? _____

Alcohol: _____drinks per week. History of Alcoholism? Yes ● No ●

What is your approximate daily consumption of the following: Coffee/Tea _____cups per day / week / month?

Other intoxicating or mind altering drugs? (specify):_____

FAMILY HISTORY

Fill in the following information about your family: ***Check if any of your relatives have had the following:***

Relation	Age	State of Health	Age at Death	Cause of Death			Disease	Relationship To You
Father						Yes ● No ●	Diabetes	
Mother						Yes ● No ●	Heart Disease	
Brothers						Yes ● No ●	Cancer	
						Yes ● No ●	High Blood Pressure	
						Yes ● No ●	Stroke	
						Yes ● No ●	Arthritis	
Sisters						Yes ● No ●	Asthma	
						Yes ● No ●	Chemical Dependency	
						Yes ● No ●	Kidney Disease	
						Yes ● No ●	Other	

PREOPERATIVE INFORMATION

Have you ever reacted badly to being put to sleep for surgery?..... ☐ No ☐ Yes

Has any member of your family ever reacted badly to being put to sleep for surgery?..... ☐ No ☐ Yes

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

Are you allergic to adhesive tape?..... ☐ No ☐ Yes

Do you bleed unusually easily (from cuts, surgery, or 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

Does your religion prohibit blood transfusions?..... ☐ No ☐ Yes

_____	_____	_____
Signature	**Relationship to Patient (Self, Mother, etc.)**	**Date**