



PLASTIC & HAND SURGICAL ASSOCIATES

Plastic, Reconstructive and Cosmetic Surgery
Surgery of the Hand

Patient Name _____

Date of Birth _____

Today's Date _____

Height _____ Weight _____ BMI _____ B/P _____

Medical History Questionnaire

Please list prior hospital admissions and operations

Have you taken any of these medications recently?:

Yes No

steroids

blood thinning drugs

high blood pressure drugs

tranquilizers

NSAIDS

Yes No

cortisone

frequent aspirin

arthritis medication

nitroglycerin

insulin

Other medical problems:

Physical disabilities or limitations:

List allergies or bad reactions to drugs, foods, latex:

Past Medical History: (✓ all that apply)

HEENT, NEUROLOGIC:

Yes No

Glaucoma

Double Vision

Blindness

Severe headaches

Dizzy spells, frequent fainting

Nose bleeds

Sores in mouth

Lump in face or neck

Seizures, convulsions

Any nerve trouble

CARDIOVASC., RESPIRATORY:

Yes No

Smoking _____ pack(s) daily

Heart failure

Angina, chest pain

Heart attack

Emphysema

Asthma

Chronic cough

Shortness of breath

High blood pressure

Sleep Apnea

CPAP

GENITO-URINARY:

Yes No

Bleeding with urination

Bladder infections

Venereal disease

Kidney disease

Urgent, frequent urination

GASTROINTESTINAL:

Yes No

Weight loss

Poor appetite

Ulcers, other stomach problems

Hiatal hernia and/or heartburn

Alcoholic beverages daily _____

Change in bowel habits

Liver disease

Hepatitis

HIV

Cirrhosis

Yellow jaundice

*ENDOCRINE:

Yes No

Diabetes oral / insulin

Thyroid

Gout

Arthritis

Hot or cold sensitivity

Unexplained changes in weight,
skin, or appearance

Recent swelling in hands, feet

Recent broken bones

COAGULATION:

Yes No

Frequent bruising

Bleeding / Clotting disorders

Blood clots

Medication Name / Dose / How often:

SKIN:

Yes No

Recent changes in any moles:
color, size, or appearance

Recent changes in any skin
lumps or colored areas:

Any slow healing or open sores:

Previous skin tumors or cancers:

Date of last EKG: _____

Where? _____

Recent Lab Tests: _____

Where? _____

Skin Solutions from Plastic & Hand

If you are experiencing unwanted hair growth, pigmentation, age spots, broken capillaries, rosacea, wrinkles, or scars and would like a consultation with a Skin Solutions aesthetician, please let us know so we can assist you.



PLASTIC & HAND
SURGICAL ASSOCIATES

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Surgery of the Hand

Pre-Anesthesia History

If surgery is anticipated, please provide the following additional information:

Have you, or anyone in your family, had unexplained reactions to anesthesia (e.g., changes in blood pressure, pulse, temperature, etc.)? Y N

If you have had prior anesthetics, have you had any unpleasant or unusual reactions? Y N

- Do you have any capped or loose teeth? Y N
- Do you have dental bridges or plates? Y N
- Females: Any chance you are pregnant? Y N
- Have you ever had a reaction to a blood transfusion? Y N

Consent For Surgical Procedures For Smokers

I have been advised by Plastic & Hand Surgical Associates that I must not smoke or take nicotine substitutes for a minimum of three (3) weeks before and after surgery.

It has been explained to me that the risks of surgery are much greater for smokers, and even if I am off cigarettes for three (3) weeks before and after surgery, I may still experience the residual effects of nicotine.

There is a greater risk in smokers of bad scarring, hematoma formation, poor or delayed healing, hair loss, sloughing of the skin (skin loss), and increased or prolonged bruising, hyperpigmentation.

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE; THAT THE RISKS HAVE BEEN FULLY EXPLAINED TO ME AND I WISH TO PROCEED WITH SURGERY.

Patient Signature _____ Date _____

Witness _____