Plastic + Hand
SURGICAL ASSOCIATES

Medical History Form

Office Use Only: Ht: _____Wt:_____
Blood Pressure:_____/_____

Today's Date:_____

Your Name:/Preferred name: _____
DOB:_____

What brings you in today?
_____
_____
_____

Date of injury or onset of problem:_____
Have you been treated for this problem prior to today? Yes □ No □
If yes, who have you seen? _____

Current medications/Dose/How Often: _____
_____
_____

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

Systems Review (Check all that apply)

HEENT, NEUROLOGIC
- □ Cleft palate/lip
- □ Dizzy spells, frequent fainting
- □ Eye or vision problems
- □ Headaches or migraines
- □ Hearing loss
- □ Lump in face or neck
- □ Neurological disease
- □ Nose bleeds, frequent
- □ Seizures, convulsions

CARDIOVASCULAR, RESPIRATORY
- □ Anemia
- □ Angina, chest pain
- □ Asthma
- □ Emphysema
- □ Heart attack
- □ Heart disease
- □ Heart murmur
- □ High blood pressure
- □ Hyperlipidemia
- □ Pacemaker, defibrillator
- □ Shortness of breath
- □ Sleep apnea
- □ Stroke
- □ Tuberculosis

GENITOURINARY
- □ Bladder infections
- □ Kidney or urinary problems

GASTROINTESTINAL
- □ Alcoholic beverages daily___
- □ Change in bowel habits
- □ Cirrhosis or jaundice
- □ GERD or heartburn
- □ Hepatitis
- □ Hiatal hernia
- □ HIV/AIDS
- □ Liver disease
- □ Poor appetite
- □ Ulcers or stomach problems

HAND/MUSCULOSKELETAL
- □ Arthritis
- □ Broken Bones, recent
- □ Carpal Tunnel Syndrome
- □ Numbness/tingling in hands
- □ Swelling in hands/feet

Anesthesia Concerns

Do you Smoke/use nicotine or marijuana products
- □ Yes _____packs/day

Do you have Sleep Apnea?
- □ Yes

Do you use a CPAP machine?
- □ Yes

Do you or a family member have malignant hyperthermia?
- □ Yes

Do you have Difficult Airway?
- □ Yes

COAGULATION
- □ A-Fib
- □ Bleeding disorder
- □ Blood clots
- □ Clotting disorder
- □ Bruising, frequent

BREAST
(If being seen for breast issue today)

*Mammogram required within 1 year of surgery for women over 40 years

- □ Last Mammogram

Date: _____ Where: _____

- □ Breast Cancer
- □ Chemotherapy or Radiation
- □ Breast implants or expanders

PLEASE TURN OVER

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Systems Review (Check all that apply)

ENDOCRINE
- □ Diabetes
- □ Gout
- □ Thyroid disorder

OTHER CONDITIONS
- □ ADHD
- □ Cancer _____
- □ Cellulitis
- □ Fibromyalgia
- □ Hernia
- □ Hot/cold sensitivity
- □ Lyme disease
- □ Menopausal
- □ MRSA
- □ Obesity
- □ Varicose veins
- □ Weight change

List all prior hospital admissions/surgeries/operations:_____
_____
_____
_____

Physical disabilities or limitations: _____
_____
_____

Psychiatric conditions or history: _____
_____
_____

Patient Signature: _____