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: ______________________