PATIENT MEDICAL HISTORY
PLASTIC SURGERY OF SOUTHERN CONNECTICUT, L.L.C.

Confidential Record: 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. This information will be used by your doctors for decision making in your care.

Name _____ Age _____ Height _____ Weight _____ Date _____
Please provide us with the name of your personal physician (Internist, Family Physician, Pediatrician, etc.) _____
Do you have any serious or chronic illness? No _____ Yes _____ Please explain _____

Do you have or have you ever had: (if yes, give date of occurrence)

Stroke	No	Yes	Diabetes	No	Yes	Visual Disorders	No	Yes
Cancer	No	Yes	Kidney Disease	No	Yes	Dryness of the Eyes	No	Yes
Arthritis	No	Yes	Migraines	No	Yes	Chest Pain	No	Yes
Tuberculosis	No	Yes	Frequent/Severe Headaches	No	Yes	Shortness of Breath	No	Yes
Bronchitis	No	Yes	MRSA/VRE	No	Yes	Rheumatic Fever	No	Yes
Asthma	No	Yes	Thyroid Problems	No	Yes	Mitral Valve Prolapse	No	Yes
COPD	No	Yes	Endocrine Problem	No	Yes	Valvular Heart Disease	No	Yes
Pneumonia	No	Yes	Epilepsy/Seizures	No	Yes	High Blood Pressure	No	Yes
Other Lung Problems	No	Yes	Ulcers	No	Yes	Heart Attack	No	Yes
Hepatitis	No	Yes	Bleeding Tendency	No	Yes	Abnormal Electrocardiogram	No	Yes
Other Liver Problems	No	Yes	Bleeding Gums	No	Yes	Swelling of Ankles	No	Yes
Dizzy Spells	No	Yes	Nosebleeds	No	Yes	Irregular Heartbeat (Arrhythmia)	No	Yes
Sleep Apnea	No	Yes	Abnormal Bruising	No	Yes	Other Heart Problems	No	Yes
GI Problems	No	Yes	GERD/Reflux	No	Yes	Cold Sores/Other Herpes Infection	No	Yes
Psoriasis	No	Yes	Bladder Infection	No	Yes	Other infectious disease	No	Yes
Other Skin Problems	No	Yes	Leukemia	No	Yes	Are you "HIV Positive?"	No	Yes

Please provide the names and years of any operations that you have had: _____

PLEASE NAME ANY DRUGS TO WHICH YOU ARE ALLERGIC (including local anesthetics - "novacaine," etc.)_____

PLEASE LIST ALL MEDICATIONS OR DRUGS THAT YOU USE (INCLUDE SO-CALLED "RECREATIONAL DRUGS") _____

No Yes Have you ever bled excessively from a laceration or injury, tooth extraction or pregnancy?

No Yes Do you take aspirin regularly? How often? _____

No Yes Do you take any drug containing salicylates or anti-inflammatory medications (e.g. Bufferin, Anacin, Alka Seltzer, Excedrin, Motrin, Advil, Nuprin, Darvon Compound, Clinoril, Celebrex, etc.? Which ones and how often? _____

No Yes Have you taken steroids in the past two years? Why? _____

No Yes Have you ever consulted a plastic surgeon?

No Yes Do you smoke? How much? _____ For how long? _____

No Yes Do you regularly drink alcohol or beer? How much? _____

No Yes Have you had any psychiatric treatment? Please explain _____

No Yes Do you have any unsightly scars? Where? _____

No Yes Are you currently pregnant? Due Date _____ Are you currently breast feeding? _____

No Yes Any complications of pregnancy? Please explain _____

Number of pregnancies _____ Miscarriages _____ Children _____

No Yes Are you now or have you ever taken the birth control pill. When? _____

No Yes Are you seeking breast surgery? If yes, please give current bra size _____

No Yes Have you ever had a mammogram? If yes, where and when? _____

No Yes Do you have a history of significant staph infection ("MRSA"), VRE or other significant infectious disease (T.B.)?

No Yes Does anyone in your family have a history of abnormal bleeding or clotting, including phlebitis/pulmonary embolism?

PLEASE PROVIDE ANY ADDITIONAL IMPORTANT INFORMATION REGARDING YOUR MEDICAL HISTORY:

THANK YOU! Signature: _____
(parent or guardian if a minor) date