

Salem Plastic Surgery, Inc.

MEDICAL HISTORY FORM

CHIEF COMPLAINT/PROBLEM: _____

 REFERRING DOCTOR: _____
 MEDICAL DOCTOR: _____

NAME: _____
 DATE: _____
 DATE OF BIRTH: _____
 AGE: _____ SEX: _____
 HEIGHT: _____
 WEIGHT: _____

Please assist us with developing an accurate medical history for you by answering the following questions. Do you presently have or have you ever in the past had any of the following medical conditions. Simply check the appropriate "Yes" or "No" space.

	<u>YES</u>	<u>NO</u>
<u>LUNGS</u>		
Pneumonia	_____	_____
Born with any lung disease	_____	_____
Cough or cold (presently)	_____	_____
Bronchitis	_____	_____
Asthma	_____	_____
Emphysema	_____	_____
Smoke ___ cigarettes per day	_____	_____
for ___ years	_____	_____
Positive TB Test	_____	_____
If yes, have you had BCG vaccine	_____	_____
Treated for TB	_____	_____
<u>HEART</u>		
Born with any heart disease	_____	_____
Heart murmur	_____	_____
Rheumatic fever	_____	_____
High blood pressure	_____	_____
Skipped heart beats	_____	_____
Chest pains	_____	_____
Hardening of the arteries	_____	_____
Heart failure	_____	_____
Heart attacks	_____	_____
<u>BLOOD</u>		
Sickle cell trait or disease	_____	_____
Other disease of blood cells	_____	_____
Abnormal blood clotting	_____	_____
<u>LIVER</u>		
Alcoholic beverages	_____	_____
How much/often _____	_____	_____
Recreational drugs _____	_____	_____
Infectious disease such as	_____	_____
Hepatitis, HIV, etc.	_____	_____
Jaundice	_____	_____
Other liver disease	_____	_____
<u>GASTROINTESTINAL</u>		
Reflux	_____	_____
Irritable bowel syndrome	_____	_____
Hiatal hernia	_____	_____
<u>KIDNEY</u>		
Born with kidney disease	_____	_____
Kidney infections	_____	_____
Kidney stones	_____	_____
Kidney failure	_____	_____
Urinary tract infections	_____	_____
<u>NERVOUS SYSTEM</u>		
Born with nervous system abnormality	_____	_____
Brain disease	_____	_____
Spinal cord disease	_____	_____
Nerve disease	_____	_____
Epilepsy	_____	_____
Stroke	_____	_____
Depression	_____	_____
<u>ENDOCRINE</u>		
Diabetes	_____	_____
Thyroid disease	_____	_____
<u>CHILDREN?</u>		
Ages _____	_____	_____

	<u>YES</u>	<u>NO</u>
<u>OTHER</u>		
Are you being treated for any other conditions not listed.	_____	_____
If _____	yes,	describe

<u>EYE</u>		
Glaucoma	_____	_____
Wear contact lenses	_____	_____
<u>DENTAL</u>		
Bridges, crowns, dentures	_____	_____
Loose teeth	_____	_____
<u>ANESTHETIC HISTORY</u>		
Allergy to any drug used in dental work, anesthesia and surgery	_____	_____
Any blood relative have an allergy to anesthesia drug	_____	_____
How many times have you had anesthesia for surgery in the past _____		
Date of last general anesthesia _____		
Any problems resulting from any anesthesia ever administered to you	_____	_____
Have you ever taken steroids (Example: Cortisone or prednisone)	_____	_____
ARE YOU PREGNANT		
Last menstrual period _____		
Date of last Pap smear _____		
Last Mammogram: Date _____ Location _____		
PERSONAL OR FAMILY HISTORY OF CARCINOMA (Cancer)		
If yes, explain _____		

HISTORY OF INJURY		
If yes, explain _____		

PREVIOUS SURGERIES AND/OR HOSPITALIZATIONS		

LIST ALL MEDICATIONS YOU ARE ALLERGIC TO		

LIST ALL PRESCRIPTION MEDICATIONS THAT YOU TAKE		

PATIENT/GUARDIAN SIGNATURE