

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.

	YES	NO		YES	NO
LUNGS			OTHER		
Pneumonia	_____	_____	Are you being treated for any other conditions not listed. If yes, describe _____	_____	_____
Born with any lung disease	_____	_____	EYE		
Cough or cold (presently)	_____	_____	Glaucoma	_____	_____
Bronchitis	_____	_____	Wear contact lenses	_____	_____
Asthma	_____	_____	DENTAL		
Emphysema	_____	_____	Bridges, crowns, dentures	_____	_____
Smoke _____ cigarettes per day	_____	_____	Loose teeth	_____	_____
for _____ years	_____	_____	ANESTHETIC HISTORY		
Positive TB Test	_____	_____	Allergy to any drug used in dental work, anesthesia and surgery	_____	_____
If yes, have you had BCG vaccine	_____	_____	Any blood-relative have an allergy to anesthesia drug	_____	_____
Treated for TB	_____	_____	How many times have you had anesthesia for surgery in the past _____	_____	_____
HEART			Date of last general anesthesia _____	_____	_____
Born with any heart disease	_____	_____	Any problems resulting from any anesthesia ever administered to you	_____	_____
Heart murmur	_____	_____	Have you ever taken steroids (Example: Cortisone or prednisone)	_____	_____
Rheumatic fever	_____	_____	ARE YOU PREGNANT	_____	_____
High blood pressure	_____	_____	Last menstrual period _____	_____	_____
Skipped heart beats	_____	_____	Date of last Pap smear _____	_____	_____
Chest pains	_____	_____	PERSONAL OR FAMILY HISTORY OF CARCINOMA (Cancer)	_____	_____
Hardening of the arteries	_____	_____	If yes, explain _____	_____	_____
Heart failure	_____	_____	HISTORY OF INJURY		
Heart attacks	_____	_____	If yes, explain _____	_____	_____
BLOOD			PREVIOUS SURGERIES AND/OR HOSPITALIZATIONS		
Sickle cell trait or disease	_____	_____	_____	_____	_____
Other disease of blood cells	_____	_____	_____	_____	_____
Abnormal blood clotting	_____	_____	_____	_____	_____
LIVER			LIST ALL MEDICATIONS YOU ARE ALLERGIC TO		
Alcoholic beverages	_____	_____	_____	_____	_____
How much/often _____	_____	_____	_____	_____	_____
Recreational drugs	_____	_____	LIST ALL MEDICATIONS YOU TAKE THAT ARE PRESCRIBED BY A PHYSICIAN		
Infectious hepatitis	_____	_____	_____	_____	_____
Jaundice	_____	_____	_____	_____	_____
Other liver disease	_____	_____	_____	_____	_____
GASTROINTESTINAL			PATIENT/GUARDIAN SIGNATURE		
Reflux	_____	_____	_____	_____	_____
Irritable bowel syndrome	_____	_____	_____	_____	_____
Hiatal hernia	_____	_____	_____	_____	_____
KIDNEY			_____		
Born with kidney disease	_____	_____	_____		
Kidney infections	_____	_____	_____		
Kidney stones	_____	_____	_____		
Kidney failure	_____	_____	_____		
Urinary tract infections	_____	_____	_____		
NERVOUS SYSTEM			_____		
Born with nervous system abnormality	_____	_____	_____		
Brain disease	_____	_____	_____		
Spinal cord disease	_____	_____	_____		
Nerve disease	_____	_____	_____		
Epilepsy	_____	_____	_____		
Stroke	_____	_____	_____		
Depression	_____	_____	_____		
ENDOCRINE			_____		
Diabetes	_____	_____	_____		
Thyroid disease	_____	_____	_____		