Piedmont Plastic Surgery, PA

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# HISTORY FORM

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ht: \_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_lbs. Primary Care and/orMedical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List Operations with Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Any Recent Problems With:

Lungs □ YES □ NO Heart □ YES □ NO

High Blood Pressure □ YES □ NO Stroke □ YES □ NO

Seizures □ YES □ NO Cancer □ YES □ NO

Diabetes □ YES □ NO Urination □ YES □ NO

Stomach or Intestines □ YES □ NO Musculoskeletal □ YES □ NO

Eyes, Ears, Throat □ YES □ NO Enlarged Lymph Nodes □ YES □ NO

Bleed or Bruise Easily □ YES □ NO Skin □ YES □ NO

Breasts □ YES □ NO

Tuberculosis (TB) □ YES □ NO Resistant infection (MRSA, VRE) □ YES □ NO

Have you ever received blood □ YES □ NO If so, When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Women:

Bra size \_\_\_\_\_inches \_\_\_\_\_\_\_cup

Number of children \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Tetanus Shot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you answered “YES” to any of the above questions, please provide details:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current Medications (including vitamins and herbs): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Drug Allergies: Circle Reaction: rash, nausea, itching, other

Habits: Cigarettes \_\_\_\_\_\_\_ packs/day \_\_\_\_\_\_ Alcohol per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you do not smoke, did you ever? Y N If yes, how many years? \_\_\_\_\_\_ Year you quit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used other (recreational) drugs? Y N

Please list drug use, recreational/substance abuse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List diseases that run in the family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_