EDWIN AUSTIN
MD, FACS
Plastic and Reconstructive Surgery

MEDICAL HISTORY FORM

Name _____ Primary Physician _____

Present concern for which you are seeing Dr. Austin: _____

Other physicians, including plastic surgeons, you have consulted about this concern (include dates): _____

_____

I would like additional information on : ❑ Breast Implants ❑ Tummy Tuck ❑ Liposuction ❑ Botox® ❑ Restylane®
❑ Skin Care Products ❑ Chemical Peels ❑ Fine Lines & Wrinkles ❑ Face Lift ❑ Eyelids

Allergies

	Frequency and duration of use
1) _____	Coffee/Tea _____ /day for _____ yr.
2) _____	Tobacco _____ /day for _____ yr.
3) _____	Alcohol _____ /day for _____ yr.

All Medications presently using and dosages/frequency

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Personal Medical History

Have you had any disorders of the Following

	Yes	No		Yes	No
Eyes & Ears	❑	❑	Nervous System	❑	❑
Nose / Sinus & Throat	❑	❑	Blood	❑	❑
Heart / Blood Vessels	❑	❑	Bones / Joints	❑	❑
Breasts	❑	❑	Urinary System	❑	❑
Lungs	❑	❑	Psychiatric	❑	❑
Gastrointestinal	❑	❑	Reproductive System	❑	❑

Notes _____

_____

_____

_____

_____

Major Injuries/Illness

	Year/Duration
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

Previous Operations

1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

	Age	State of Health
Mother	_____	_____
Father	_____	_____
Brother(s)	_____	_____
	_____	_____
	_____	_____
Sister(s)	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
Children	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Family Medical History

Has any relative had:

	Yes	No
Tuberculosis	❑	❑
Cancer	❑	❑
High Blood Pressure	❑	❑
Heart Disease	❑	❑
Diabetes	❑	❑
Kidney Disease	❑	❑
Asthma	❑	❑
Lung Disease	❑	❑
Blood Disorder	❑	❑
Epilepsy	❑	❑
Mental Disorder	❑	❑

Do you take aspirin products regularly? _____ Yes ❑ No ❑
Do you have high blood pressure? _____ Yes ❑ No ❑
Do you have shortness of breath with walking or when lying down? _____ Yes ❑ No ❑
Do you get chest pain regularly? _____ Yes ❑ No ❑
Have you ever been found to have a heart murmur? _____ Yes ❑ No ❑
Have you ever had scarlet fever or rheumatic fever? _____ Yes ❑ No ❑
Do you have frequent infectious boils? _____ Yes ❑ No ❑
Have you ever taken steroid medications, cortisone, or ACTH? _____ Yes ❑ No ❑
Have you ever had a bad reaction to local anesthetic? _____ Yes ❑ No ❑
Does your religion prohibit blood transfusions? _____ Yes ❑ No ❑
Do you have unusual bleeding from cuts, surgery, or tooth extractions? _____ Yes ❑ No ❑
Do you form large scars or keloids? _____ Yes ❑ No ❑
Have you ever had psychiatric care or been advised to see a psychiatrist? _____ Yes ❑ No ❑
Do you have or have you had any significant emotional problems? _____ Yes ❑ No ❑

Height _____ Ft. _____ In. Weight _____ lbs. Weight change past year of _____ lbs. ❑ Loss ❑ Gain Date of last menstrual period _____

Date of last physical exam: _____ Did it include EKG? ❑ Yes ❑ No Chest x-ray ❑ Yes ❑ No Examining Doctor _____