OREGON PLASTIC SURGEONS

MEDICAL HISTORY

DATE: _____/_____/_____

NAME: _____ Age: _____ GENERAL HEALTH: Poor_____ Fair_____ Good _____

If not good, please explain: _____

Height_____ Weight _____ Weight change past year of _____ lbs. ☐ Loss ☐ Gain Date of last menstrual period _____

PRIMARY CARE PHYSICIAN: Name_____ City _____ Phone _____

When did you last have the following? Physical Exam:_____ EKG:_____ Chest X-ray:_____ Blood work:_____

Frequency and duration of use (circle one):

Coffee/Tea _____ day/week for_____ yr.

Tobacco _____ day/week for_____ yr.

Alcohol_____ day/week for_____ yr.

List **ALL MEDICATIONS** & herbal supplements presently using and daily dosages:

1_____ 4_____

2_____ 5_____

3_____ 6_____

ALLERGIES:

_____

_____

_____

PREVIOUS OPERATIONS

	Year	Complications
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

MAJOR INJURIES OR ILLNESSES

	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Personal Medical History

Have you had any problems with any of the following?

	YES	NO		YES	NO
Eyes & Ears	☐	☐	Nervous System	☐	☐
Nose/Sinus & Throat	☐	☐	Blood	☐	☐
Heart/Blood Vessels	☐	☐	Bones/Joints	☐	☐
Breasts	☐	☐	Urinary System	☐	☐
Lungs (Asthma, Bronchitis)	☐	☐	Psychiatric	☐	☐
Gastrointestinal (Reflux)	☐	☐	Reproductive System	☐	☐
Liver (Hepatitis)	☐	☐	Other (Diabetes, etc.)	☐	☐

COMMENTS _____

_____

_____

_____

Family Medical History

	Age	General Health
Mother	____	_____
Father	____	_____
Brother(s)	____	_____
	____	_____
	____	_____
Sister(s)	____	_____
	____	_____
	____	_____
Children	____	_____
	____	_____
	____	_____
	____	_____

Has any blood relative had:

	YES	NO
Tuberculosis	☐	☐
Cancer	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Diabetes	☐	☐
Kidney Disease	☐	☐
Asthma	☐	☐
Lung Disease	☐	☐
Blood Disorder	☐	☐
Epilepsy	☐	☐
Mental Disorder	☐	☐
Blood Clots	☐	☐

	YES	NO
Do you take aspirin products regularly? _____	☐	☐
Have you ever had a bad reaction to a GENERAL anesthetic? a LOCAL anesthetic? _____	☐	☐
Are you subject to motion sickness or nausea with anesthesia? _____	☐	☐
Have you ever had previous leg blood clots or a pulmonary embolus? _____	☐	☐
Do you have high blood pressure? _____	☐	☐
Have you ever had scarlet fever or rheumatic fever? _____	☐	☐
Have you ever been told you have a heart murmur? _____	☐	☐
Have you ever had any chest pain? _____	☐	☐
Do you have shortness of breath with walking or when lying flat? _____	☐	☐
Do you have, or have you ever had, any unusual bleeding from cuts, surgery or tooth extractions? _____	☐	☐
Do you form large scars or keloids? _____	☐	☐
Do you have frequent infections, boils or cold sores? _____	☐	☐
Have you take steroid medications, cortisone or ACTH? _____	☐	☐
Does your religion prohibit blood transfusions? _____	☐	☐
Do you have or have you ever had psychiatric care or been advised to see a psychiatrist? _____	☐	☐

PRESENT CONCERN:

Specific condition(s) for which you are being seen: _____

_____

Other physicians, including plastic surgeons, you have consulted about this condition: _____

_____