

NICHTER / HOROWITZ

PACIFIC CENTER FOR PLASTIC SURGERY

MEDICAL HISTORY

Name: _____ Sex: _____ Age: _____ DOB: _____

Reason for Visit (chief complaint including date of onset): _____

Height: _____ Weight: _____

DO YOU OR HAVE YOU EVER HAD:

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING TENDENCIES	<input type="checkbox"/>	<input type="checkbox"/>	SYNCOPE
<input type="checkbox"/>	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	SWOLLEN GLANDS
<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	GLASSES/CONTACTS
<input type="checkbox"/>	<input type="checkbox"/>	IRREGULAR HEART BEATS	<input type="checkbox"/>	<input type="checkbox"/>	TRANSFUSIONS	<input type="checkbox"/>	<input type="checkbox"/>	VISUAL IMPAIRMENT/DRY EYE
<input type="checkbox"/>	<input type="checkbox"/>	THROMBOPHLEBITIS/BLOOD CLOTS	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	CATARACTS
<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER/HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT EAR PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS/JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT NASAL BLEEDING
<input type="checkbox"/>	<input type="checkbox"/>	SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	SKIN PROBLEM REQUIRING MEDS
<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA/EMPHYSEMA/WHEEZING	<input type="checkbox"/>	<input type="checkbox"/>	BLOODY STOOL	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL ILLNESS
<input type="checkbox"/>	<input type="checkbox"/>	COLLAGEN VASCULAR DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	BOWEL OBSTRUCTIONS	<input type="checkbox"/>	<input type="checkbox"/>	BREAST LUMPS OR DISCHARGE
<input type="checkbox"/>	<input type="checkbox"/>	PNEUMONIA	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	BREAST IMPLANTS
<input type="checkbox"/>	<input type="checkbox"/>	BACK OR NECK INJURIES	<input type="checkbox"/>	<input type="checkbox"/>	BLADDER INFECTION	<input type="checkbox"/>	<input type="checkbox"/>	HERNIA OF: _____
<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/HERPES	<input type="checkbox"/>	<input type="checkbox"/>	ABNORMAL X-RAY/MAMMOGRAM	<input type="checkbox"/>	<input type="checkbox"/>	RECENT WEIGHT LOSS OR GAIN
<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	SEIZURES			AMOUNT: _____
<input type="checkbox"/>	<input type="checkbox"/>	INJURIES OR FRACTURES: WHERE/WHEN?: _____				<input type="checkbox"/>	<input type="checkbox"/>	CANCER OF/DATE: _____
<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____						
<input type="checkbox"/>	<input type="checkbox"/>	MEDICATIONS (include vitamins/herbs/over-the-counter): _____						

ALLERGIES & SIDE EFFECTS: _____

OPERATIONS/HOSPITALIZATIONS/ER VISITS/COSMETIC PROCEDURES (LIST & DATE): _____

PRIMARY CARE DOCTOR: _____ Phone: () _____ LAST EXAM: _____

GYNECOLOGIST: _____ Phone: () _____ LAST EXAM: _____

ONSET OF LAST MENSTRUAL CYCLE: (Date) _____ REGULAR IRREGULAR

NUMBER OF PREGNANCIES: _____ NUMBER OF BIRTHS: _____ METHOD OF BIRTH CONTROL: _____

COULD YOU BE PREGNANT NOW? YES NO

<input type="checkbox"/> <input type="checkbox"/> FAMILY HISTORY OF DISEASE : (LIST FAMILY MEMBER AND DATE)	<input type="checkbox"/> DIABETES _____	<input type="checkbox"/> CANCER _____
	<input type="checkbox"/> STROKE _____	<input type="checkbox"/> HYPERTENSION _____
	<input type="checkbox"/> HEART DISEASE _____	<input type="checkbox"/> OTHER _____

SOCIAL HISTORY

DO YOU SMOKE? YES/How Much? _____ NO/Date Quit: _____ NEVER

DO YOU DRINK ALCOHOL? YES/How Often? _____ NO

LABORATORY STUDIES

(DATE & LOCATION)

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD TESTS (CBC) _____	<input type="checkbox"/>	<input type="checkbox"/>	CHEST XRAY/MRI/CT _____
<input type="checkbox"/>	<input type="checkbox"/>	EKG (CARDIOGRAM) _____	<input type="checkbox"/>	<input type="checkbox"/>	OTHER LAB _____
<input type="checkbox"/>	<input type="checkbox"/>	MAMMOGRAM Date: _____ Location: _____			

I certify that I have disclosed my medical history to the best of my knowledge.

Patient's Signature

Date