**GRAND STRAND PLASTIC & RECONSTRUCTIVE SURGERY CENTER, P.A.**

**PATIENT’S PERSONAL MEDICAL HISTORY FORM**

**FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REASON FOR VISIT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SURGICAL HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Past Surgeries/Hospitalizations (if none, please print none)** | | | | |
|  | **Surgery/Hospitalization** | **Date** | **Anesthesia Complications** | **Notes** |
| **1** |  |  |  |  |
| **2** |  |  |  |  |
| **3** |  |  |  |  |
| **4** |  |  |  |  |
| **5** |  |  |  |  |
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| **9** |  |  |  |  |
| **10** |  |  |  |  |

**PAST MEDICAL HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **Details** |  | **Yes** | **Details** |
| No significant past medical history |  |  | **INFECTIOUS DISEASE** |  |  |
| **AUTOIMMUNE** |  |  | Lyme Disease |  |  |
| Lupus |  |  | Hepatitis |  |  |
| Sjogren’s Disease |  |  | History of MRSA Infection |  |  |
| Rheumatoid Arthritis |  |  | HIV/AIDS |  |  |
| Scleroderma |  |  | Tuberculosis |  |  |
| Other Autoimmune |  |  | Other Infectious Disease |  |  |
| Fibromyalgia |  |  | **NEUROLOGIC** |  |  |
| **CARDIOVASCULAR** |  |  | Alzheimer’s Disease |  |  |
| High Blood Pressure |  |  | Stroke/TIA |  |  |
| Heart Disease |  |  | Convulsions/Seizures |  |  |
| Heart Murmur |  |  | Fainting/Weakness |  |  |
| Chest Pain/Tightness |  |  | MS |  |  |
| Irregular Heartbeat |  |  | Parkinson’s Disease |  |  |
| Peripheral Vascular Disease |  |  | Peripheral Neuropathy |  |  |
| Varicose Veins (Venous Insufficiency) |  |  | Psychiatric Care |  |  |
| Other Cardio |  |  | Other Neurologic Related |  |  |
| **CANCER HISTORY** |  |  | **OPHTHALMOLOGIC** |  |  |
| Breast Cancer |  |  | Double Vision |  |  |
| Skin Cancer |  |  | Dry Eyes |  |  |
| Other Cancer |  |  | Cataracts |  |  |
| **CUTANEOUS** |  |  | Glaucoma |  |  |
| Acne |  |  | Blindness/Loss of Vision |  |  |
| Eczema/Psoriasis |  |  | Contact Lenses |  |  |
| Skin Disease |  |  | Other Ophthalmic |  |  |
| **ENDOCRINE** |  |  | Other Eye Related |  |  |
| Diabetes |  |  | **OROPHARYNGEAL** |  |  |
| Thyroid Disorder |  |  | Airway obstruction |  |  |
| Polycystic Ovary |  |  | Sinus Infections |  |  |
| Pituitary or Adrenal |  |  | Hay Fever |  |  |
| Other Endocrine |  |  | Fever Blisters |  |  |
| **GASTROINTESTINAL** |  |  | Loss of Hearing |  |  |
| Ulcers |  |  | Other ENT Related |  |  |
| Hiatal Hernia |  |  | **PULMONARY** |  |  |
| Jaundice |  |  | Bronchitis |  |  |
| Other GI |  |  | Pneumonia |  |  |
| **GENITOURINARY** |  |  | Shortness of Breath |  |  |
| Kidney Stones |  |  | Asthma |  |  |
| Stress Incontinence |  |  | COPD/Emphysema |  |  |
| Urinary Tract Infection |  |  | Other Pulmonary |  |  |
| Gynecologic Issues |  |  | **TRAUMA/MISC** |  |  |
| Other GU |  |  | History of Trauma or Injury |  |  |
| **HEMATOLOGIC/BLOOD** |  |  | Radiation Treatment or Exposure |  |  |
| Leukemia/Lymphoma |  |  | Environmental Exposures |  |  |
| Anemia |  |  | **OTHER IMPORTANT ISSUES:** |  |  |
| Polycythemia |  |  |  |  |  |
| Bleeding Disorder |  |  |  |  |  |
| Clotting Disorder |  |  |  |  |  |
| Other Hematologic |  |  |  |  |  |

**ALLERGIES AND MEDICATIONS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **ALLERGIES:** If none please indicate NKDA | | | **CURRENT MEDICATIONS:**  **(Please PRINT and list all current prescription medications and over-the-counter medication or supplements you take on a regular basis)** Please indicate N/A if not applicable | | |
| **Allergy** | **Reaction** | **Notes** | **Medication** | **Dosage (Amount)** | **Prescribed by:** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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**FAMILY HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Check if Yes** | **Afflicted Family Member** | **Notes** |
| No Contributing Family History |  |  |  |
| Abnormal Bleeding |  |  |  |
| Abnormal Clotting |  |  |  |
| Adopted |  |  |  |
| Anesthesia Problems |  |  |  |
| Autoimmune Disorders |  |  |  |
| Breast Cancer |  |  |  |
| Endocrine Disease |  |  |  |
| Hemophilia |  |  |  |
| Malignant Hypothermia |  |  |  |
| Other Cancer |  |  |  |
| Ovarian Cancer |  |  |  |
| Skin Cancer |  |  |  |
| Skin Disease |  |  |  |
| Unknown |  |  |  |
| vonWillebrand |  |  |  |

**SOCIAL HISTORY (check appropriate boxes)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ALCOHOL** | | **HIGH RISK FACTORS** | | |
|  | Denies alcohol use |  | Denies high risk factors | |
|  | Admits alcohol use socially |  | Admits high risk factors | |
|  | Admits alcohol use daily |  |  | |
|  | Admits to hx of alcoholism |  |  | |
| **ILLEGAL DRUGS** | | **SMOKING STATUS:** | | |
|  | Denies using illegal drugs | Smoking Status | | Yes No |
|  | Admits to using illegal drugs | Started | |  |
|  | Admits to history of drug abuse | Ended | |  |

**MISCELLANEOUS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Adverse Reactions or Sickness From:** | Yes | No | Notes |
| Aspirin products |  |  |  |
| Novacaine, Xylocaine, or other local anesthetics |  |  |  |
| Adhesive tapes |  |  |  |
| Iodine |  |  |  |
| Antibiotics |  |  |  |
| Latex rubber |  |  |  |
| **In the past six months have you taken:** |  |  |  |
| Steroids |  |  |  |
| Blood pressure medicine |  |  |  |
| Diet drugs/herbs |  |  |  |
| Accutane |  |  |  |
| High dose vitamins |  |  |  |
| **General:** |  |  |  |
| Scar easily |  |  |  |
| Cold sores/fever blisters |  |  |  |
|  |  |  |  |

**PERSONAL SOCIAL HISTORY**

|  |  |  |
| --- | --- | --- |
| **MARTIAL STATUS:** | **YES** | **NOTES:** |
| Single |  |  |
| Engaged |  |  |
| Married |  |  |
| Separated |  |  |
| Divorced |  |  |
| Widowed |  |  |
| Partner |  |  |
| N/A or withheld |  |  |
| **WORK HISTORY:** |  |  |
| Employed |  |  |
| Currently Unemployed |  |  |
| Retired |  |  |
| Disabled |  |  |
| Part time work |  |  |
| Student |  |  |
| Homemaker |  |  |
| Pertinent hobbies or activities |  |  |
| Status withheld |  |  |

**FEMALE QUESTIONS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **N/A** | **Notes** |
| History of Breast Disease |  |  |  |  |
| Have you nursed (breast fed) or are you nursing? |  |  |  |  |
| Are you or do you think you may be pregnant? |  |  |  |  |
| Family History of Breast/Ovarian Cancer |  |  |  |  |
| Other Info |  |  |  |  |

**MORE FEMALE QUESTIONS**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Notes** | **BREAST SURGERY PATIENTS** | **Notes** |
| Date of last menstrual period? |  | What is your current bra and cup size? |  |
| Number of pregnancies? |  | What size do you want? |  |
| Number of live births? |  | Are you interested in a breast lift? |  |
| Last mammogram? |  | Are you interested in breast reduction? |  |

**HEIGHT/ WEIGHT/BLOOD PRESSURE**

|  |  |  |
| --- | --- | --- |
|  | | **Please indicate any additional pertinent health information below:** |
| Height (inches) |  |  |
| Weight (lbs) |  |  |
| Systolic Blood Pressure (top) |  |  |
| Diastolic Blood Pressure (bottom) |  |  |

**I understand that the above information and any explanations on the form are important for my care (or the patient’s if filled out by someone other than the patient) during and after surgery. I therefore certify that the answers and explanations are true and correct to the best of my knowledge.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Signature of Patient) (Signature Parent/Guardian)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Date**