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Certified American Board of Plastic Surgery
Certified American Board of Surgery
MEDICAL HISTORY

INFORMATION IS STRICTLY CONFIDENTIAL. Please answer all questions to enable the doctor to make proper medical decisions.

LAST NAME _____ FIRST _____ MIDDLE _____

AGE _____ SEX _____ HEIGHT _____ WEIGHT _____ RIGHT/LEFT HANDED _____

OCCUPATION _____ RELIGION _____

(optional)

LIST ALL PREVIOUS SURGERIES: _____ DATE: _____

LIST ALL MEDICAL PROBLEMS YOU HAVE HAD:

Date Resolved	Current	Describe Problem	Family History	Date Resolved	Current	Describe Problem	Family History
_____	<input type="checkbox"/>	High Blood Pressure	_____	_____	<input type="checkbox"/>	Heart Problems	_____
_____	<input type="checkbox"/>	Lung Problems	_____	_____	<input type="checkbox"/>	Cancer	_____
_____	<input type="checkbox"/>	Arthritis	_____	_____	<input type="checkbox"/>	Intestinal Problems	_____
_____	<input type="checkbox"/>	Thyroid Problems	_____	_____	<input type="checkbox"/>	Ulcers	_____
_____	<input type="checkbox"/>	Asthma	_____	_____	<input type="checkbox"/>	Diabetes	_____
_____	<input type="checkbox"/>	Kidney Problems	_____	_____	<input type="checkbox"/>	Stroke	_____
_____	<input type="checkbox"/>	Circulation Problems	_____	_____	<input type="checkbox"/>	TB	_____
_____	<input type="checkbox"/>	Varicose Veins	_____	_____	<input type="checkbox"/>	HIV	_____
_____	<input type="checkbox"/>	Liver Disease	_____	_____	<input type="checkbox"/>	Blood Clots	_____
_____	<input type="checkbox"/>	Bleeding Tendencies	_____	_____	<input type="checkbox"/>	Psychological Problems	_____
_____	<input type="checkbox"/>	Ever Received Transfusion	_____	_____	<input type="checkbox"/>	Drug Abuse	_____

LIST ANY OTHER MEDICAL CONDITIONS NOT CONTAINED ABOVE:

LIST: Medications/Nutritional Supplements/Herbs DOSE REASON FOR TAKING:

LIST DRUG ALLERGIES:

SMOKING:
 Yes, but I've quit as of _____. I smoked _____ packs per day. Number of years smoked _____
 Yes, currently. I smoke _____ packs per day. Number of years smoked _____
 No, never have smoked.

 SIGNATURE OF RESPONSIBLE PARTY DATE