

Yarrow Bay Plastic Surgery

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Name: (First) _____ (MI) _____ (Last) _____

Date of Birth: ____/____/____ Today's Date: ____/____/____

Primary Concern / Procedure: _____

Primary Care Provider/Phone Number: _____

Referred By: _____

Allergies:

Drug: _____ Reaction(s): _____

Latex Allergy: (Y) ____ (N) ____ Environmental: _____

Medical History / Review of Systems:

Height: _____ Weight: _____

Have you ever had the following?

(Please circle ANY that apply)

- Heart Disease / Heart Murmur
- Mitral Valve Prolapse
- High Blood Pressure
- Bleeding Tendencies
- Lupus or Autoimmune Disease
- Blood Clot (you or family member)
- Blood Clotting Disorder (you or family member)
- Hepatitis / HIV
- Anemia
- Herpes (cold sore, genital or shingles)
- Diabetes
- Acid Reflux Disease
- Asthma
- Sleep Apnea / Snoring
- Migraines / Headaches
- Stroke / TIA
- Psychiatric Care
- Arthritis
- Cancer (of _____)
- (Females) History of miscarriage

Have you recently had?

(Please circle ANY that apply)

- Fever, chills, nausea, vomiting, diarrhea
- Skin rashes, lumps
- Frequent colds, sinus congestion
- Taken blood thinners, When? _____
- Anxiety, depression
- Changes in vision, hearing
- Sore throat, bleeding gums
- Lumps in neck
- Breast masses, nipple discharge
- Chest pain, shortness of breath, difficulty breathing
- Heartburn, abdominal pain
- Numbness/tingling/cramping in hands and/or feet
- Swelling of hands and/or feet
- Seizures, paralysis

Previous Surgeries / Hospitalizations and Date:

Current Medication(s):

Family Medical History:

Social History:

Use of tobacco:

- I am a non-smoker who has never used tobacco products.
 I am a former smoker who quit _____ months/years ago.
 I am a current smoker and I smoke _____ cigarettes/packs per day.

Use of alcohol:

- I never use alcohol.
 I occasionally use alcohol. Approximately _____ drink(s) per week/month.
 I am a regular user of alcohol. Approximately _____ drink(s) per day.

Use of drugs:

- I never use drugs.
 I only use doctor prescribed medications.
 I use drugs recreationally. Please list: _____

Exercise regime: _____

Type of employment: _____

I hereby declare that the information I have provided on this form is a true and accurate record to the best of my knowledge.

Patient Signature

Date

The following line is to be signed by your doctor or nurse.

Reviewed by

Date