YARROW BAY
PLASTIC SURGERY

Today's Date:_____

Name: _____
First Middle Last "nickname"

Date of Birth: _____

Primary Concern/Procedure: _____

Allergies:

Drug(s): _____ Reaction(s): _____

_____

Latex Allergy: Y / N Environmental: _____

Primary Care Provider/Number: _____

Height: _____ Weight: _____ Goal Weight: _____ LMP: _____

Personal Health History: Please read through the following list and check each that applies to you past and/or present.

- o Heart Disease
- o Heart Murmur (beyond childhood)
- o Mitral Valve Prolapse
- o High Blood Pressure
- o Heart Attack
- o Stroke/TIA
- o Blood Disorder:
- o Bleeding Tendencies
- o Blood Clots
- o Anemia: *last checked:*
- o Bleeding Gums
- o History of Miscarriage
- o Taken blood thinners:
  date last dose:
- o Autoimmune Disease
- o Lupus
- o Arthritis
- o Thyroid: *last checked:*
- o Diabetes: *last Hgb a1c:*
- o Migraines: *how often:*
- o Headaches: *how often:*
- o Seizures
- o Paralysis
- o HIV
- o Hepatitis: type_____
- o Herpes: type _____
- o Cancer of: _____
- o Other:
- o Sleep Apnea / C-pap Y/N
- o Difficulty Breathing
- o Asthma
- o Heartburn/Acid Reflux
- o Swelling in hands / feet
- o Numbness/Tingling hands/feet
- o Skin: rashes/lumps
- o Changes in: vision/hearing
- o Recent: fever/vomiting/colds
  sinus congestion/infections
- o Psychiatric Care
- o Anxiety
- o Depression
- o Breast feeding (date stopped:)

- o Have you ever had any difficulty with anesthesia? (explain) _____

Please list ALL previous Surgeries/Hospitalizations with dates:

_____

_____

_____

_____

Current Medications (including vitamins and supplements):

Family Medical History:

o Cancer:	o Heart Disease:	o Diabetes:

o Other:

Social History:

Use of tobacco/nicotine:

- o I am a non-smoker who has never used tobacco/nicotine products.
- o I am a former smoker who quit _____months / years ago.
- o I am current smoker and/or user of nicotine products. I smoke _____ cigarettes / packs per day.

Use of alcohol:

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

Use of drugs:

- o I never use drugs, unless prescribed by my doctor.
- o I use recreational drugs: (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 of my health history, to the best of my knowledge.

Patient Signature Date

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

Reviewed by: Date

6 month review/update with patient	Date