Cosmetic and Plastic Surgery of Central Pennsylvania, LLC

PATIENT MEDICAL INFORMATION PAGE 1 OF 2

Name: [Last]_____[First]_____[MI] Account#_____

☐ M ☐ F Age___Weight_____Height _____

Personal Medical History

Allergies: (*Penicillin, Latex, Novocain...list all and reactions*)_____

_____

(Check all that apply)

□ High Blood Pressure	□ Diabetes	□ HIV or AIDS	□ High Cholesterol
□ Previous Heart Attack	□ Kidney Disease	□ Hepatitis(A,B,C)	□ _____
□ Heart Disease	□ Liver Disease	□ Stroke	□ _____
□ Heart Failure	□ Psychiatric Disease	□ Emphysema	□ _____
□ Seizures	□ Easy Bleeding	□ Blood Clots	□ _____
□ Chest Pain	□ Gastric Reflux	□ Thyroid Disease	□ _____
□ Asthma	□ Cancer	□ Rheumatic fever	□ _____

Any family or personal problems with anesthesia?_____Yes_____No, Malignant Hyperthermia? ☐ Yes ☐ No

If yes, what happened? _____

Family Medical History

(Check all that apply) Which family members?

□ High Blood Pressure	□ Diabetes	□ HIV or AIDS	□ _____
□ Previous Heart Attack	□ Kidney Disease	□ Hepatitis(A, B, C)	□ _____
□ Heart Disease	□ Liver Disease	□ Stroke	□ _____
□ Heart Failure	□ Psychiatric Disease	□ Emphysema	□ _____
□ Seizures	□ Easy Bleeding	□ Blood Clots	□ _____
□ Chest Pain	□ Gastric Reflux	□ Thyroid Disease	□ _____
□ Asthma	□ Cancer	□_____	□ _____

Personal Operations/Surgeries/Hospitalizations

_____ _____ _____

_____ _____ _____

Medications/Vitamins/Herbal supplements & Dosage

_____ _____ _____

_____ _____ _____

_____ _____ _____

Pharmacy _____ Telephone _____ Address _____

Do you take:

Social History

☐ Yes ☐ No Blood thinners (Coumadin/Warfarin, Heparin, Plavix, Aspirin, Pradaxa/Dabigatran, Vitamin E, Fish oil)

☐ Yes ☐ No Diet Pills?

☐ Yes ☐ No Steroids in the last year? (injections such as Orthopedic joint injections or oral)

☐ Yes ☐ No Do you Smoke? If yes, number of packs per day:_____ Number of years_____Counselled to Quit____

☐ Yes ☐ No Have you used Recreational Drugs?

☐ Yes ☐ No Do you ever drink Alcohol?

If yes, what type:_____How much:_____How Often(daily/weekly/monthly,etc.): _____

Cosmetic and Plastic Surgery of Central Pennsylvania, LLC

PATIENT MEDICAL INFORMATION PAGE 2 OF 2

Name: [Last]_____[First]_____[MI] Account#_____

Review of Systems

Do you have any of the following?

CARDIOVASCULAR

High Blood Pressure ☐ Yes ☐ No
Previous Heart Attack ☐ Yes ☐ No
Chest Pain ☐ Yes ☐ No
Pacemaker/Defibulator ☐ Yes ☐ No
Heart Failure ☐ Yes ☐ No
Irregular Heart Beat ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Leg Swelling ☐ Yes ☐ No
Do you take water pills? ☐ Yes ☐ No
Other: _____

RESPIRATORY

Asthma ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No
Shortness of breath at night ☐ Yes ☐ No
Can you climb 2 flights of stairs? ☐ Yes ☐ No
Cough ☐ Yes ☐ No
Recent Chest infection ☐ Yes ☐ No
Sleep Apnea ☐ Yes ☐ No
CPAP Machine ☐ Yes ☐ No

GASTROINTES TINAL

Jaundice ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
Heartburn ☐ Yes ☐ No
Reflux ☐ Yes ☐ No

SKIN

Cancer ☐ Yes ☐ No
Radiation ☐ Yes ☐ No
new skin changes/lesions ☐ Yes ☐ No

ENDOCRINE

Diabetes ☐ Yes ☐ No
Frequent Urination ☐ Yes ☐ No
Drink a lot of fluids ☐ Yes ☐ No
Feel cold when others feel normal ☐ Yes ☐ No
Feel hot when others feel normal ☐ Yes ☐ No

PSYCHIATRIC

Anxiety ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Do you see a psychiatrist ☐ Yes ☐ No

NEUROLOGIC

Stroke ☐ Yes ☐ No
Seizures ☐ Yes ☐ No
Numbness/tingling ☐ Yes ☐ No
Fainting ☐ Yes ☐ No
Dizzy ☐ Yes ☐ No

HEMATOLOGIC/ONCOLOGIC

Prolonged bleeding ☐ Yes ☐ No
Easy bruising ☐ Yes ☐ No
Fatigue ☐ Yes ☐ No
Blood clot in legs ☐ Yes ☐ No
Blood clot in lungs ☐ Yes ☐ No
Previous family hx of blood clots ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Sickle cell disease ☐ Yes ☐ No
Radiation treatment ☐ Yes ☐ No
Immunizations current? ☐ Yes ☐ No

EYES

Cataracts ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Contact lenses ☐ Yes ☐ No

Doctor's Signature _____

Date_____