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The reason that I am here to see the doctor _____
_____

If this visit involves cancer of any type, please bring all lab work and pathology to your visit. If your visit concerns ruptured or leaking breast implants, you must bring your most recent mammogram to your visit. If you do not have them for your consult we will be unable to see you. If you do not have a mammogram as recent as 6 months, call our office and we will arrange one for you.

Confidential Record:
Information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in making decisions regarding your care.

Name: Last _____ First _____ Middle _____
Age _____ HT _____ WT _____
Day of last physical examination _____ Dr. _____
Was everything ok? Yes No
If No, list problem(s) _____
Important: Name and address of M.D. to send correspondence to: _____
_____
_____

Do you have or have you had: (Circle Yes or No. If Yes, give date)

		Date			Date			Date
Stroke	No Yes	_____	Anemia	No Yes	_____	Shortness of Breath	No Yes	_____
Heart Attack	No Yes	_____	Bleeding Tendency	No Yes	_____	Epilepsy	No Yes	_____
Chest Pains	No Yes	_____	Diabetes	No Yes	_____	Arthritis	No Yes	_____
Heart Disease	No Yes	_____	Hepatitis	No Yes	_____	Thyroid Disease	No Yes	_____
Heart Murmur	No Yes	_____	Cancer	No Yes	_____	Hay Fever	No Yes	_____
Rheumatic Heart	No Yes	_____	Kidney Disease	No Yes	_____	Excessive Scarring	No Yes	_____
Irregular Heartbeat	No Yes	_____	Tuberculosis	No Yes	_____	Stomach Ulcers	No Yes	_____
Congenital Heart	No Yes	_____	Bronchitis	No Yes	_____	Eye Disease	No Yes	_____
High Blood Pressure	No Yes	_____	Asthma	No Yes	_____	Excessive Tearing	No Yes	_____
Swelling of Ankles	No Yes	_____	Lung Disease	No Yes	_____	Psychiatric Problems	No Yes	_____
Blood Disorder	No Yes	_____	Pneumonia	No Yes	_____	Nervous Breakdown	No Yes	_____

(Diet supplements include: Fen/Phen; Redux: HCG injections)

No Yes Do you currently take diet pills/injections or have you taken within the past 2 weeks? If yes, please explain _____
No Yes Do you have a history of IV drug use, use of oral narcotics or illicit drugs? Explain _____
No Yes Do you smoke regularly? How much? _____ For how many years? _____
Or when did you quit? _____ Date of last chest X-ray _____
No Yes Do you usually drink 6 cups of coffee per day?
No Yes Do you regularly drink alcohol or beer? How much? _____

Do you know of any blood relatives who have or had: (circle and give relationship)

Stroke	No Yes	_____	Diabetes	No Yes	_____
High Blood Pressure	No Yes	_____	High Fever after surgery	No Yes	_____
Heart Attack	No Yes	_____	Bleeding Tendency	No Yes	_____
Tuberculosis	No Yes	_____	Breast Cancer	No Yes	_____
Anesthesia Problem	No Yes	_____			

Please list any regular current medications (prescriptions or over the counter drugs) that have been taken within the last month:

_____

_____

_____

_____

Please specify any aspirin-containing medication or similar medication:_____

_____

Please list names and year of any operations: _____

_____

Have you had any complications from anesthesia? _____

Name any drugs to which you are allergic including local anesthetics: _____

_____

Do you have any allergies to soaps or tapes or Bandaids? Please list:_____

_____

Any serious illnesses which you have had:_____

_____

Serious injuries or accidents: _____

_____

No Yes Do you frequently have bleeding gums?

No Yes Do you have nose bleeds? How often? _____

No Yes Have you ever bled excessively from a tooth extraction or laceration?

No Yes Do you take aspirin or arthritic medications? How often? _____

(IF YES, STOP TAKING THEM 2 WEEKS BEFORE AND 2 WEEKS AFTER SURGERY)

No Yes Have you had blood transfusions? Any adverse reactions? _____

FEMALES ONLY

No Yes Are you still having regular monthly menstrual periods?
Date of last period _____

No Yes Are you now or have you ever taken birth control pills?
When? How long? _____

No Yes Have you had any previous breast surgery? List dates and type of surgery: _____

Number of pregnancies you have had _____

Number of C-sections _____

Weight of babies at birth _____

_____ Date of last breast exam. Results _____

_____ Date of last mammogram. Results _____

_____ Date of last bone or liver scan and chest X-ray. Results _____

I certify that the above is my most current medical history and that all previous surgical complications and allergies have been listed herein.

_____ _____

Signature of Patient or Guardian Date