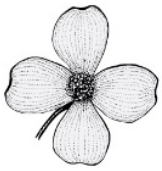
Doctor: _____
Chart #: _____



RICHMOND
PLASTIC SURGEONS

Allergy/Allergies Alert

Plastic Surgery Health Information Form

Date: _____ Name: _____ Male or Female

Birthdate: _____/_____/_____ Age: _____

Home #: _____ Cell #: _____ Work #:_____

What is the best number to reach you? _____

Height: _____ Weight: _____

Reason for Visit: _____

Pharmacy Name: _____ Pharmacy phone #:_____

Address: _____

Referring Doctor: _____

_____ Anxiety
_____ Asthma
_____ Bleeding Disorder
_____ Blindness
_____ Breast Cancer
_____ Bronchitis
_____ Cancer
_____ Chest Pain/Tightness
_____ Contact Lenses
_____ History of Deep Venous Thrombosis (blood clot in legs)
_____ Pulmonary Embolism (blood clot in lungs)
_____ Depression
_____ Diabetes
_____ Dialysis
_____ Dry Eyes and/or Burning
_____ Eczema
_____ Emphysema
_____ Epilepsy or Seizures
_____ Gall Bladder Problems
_____ Genitourinary
_____ Glaucoma
_____ Heart Attack (MI)
_____ Heart Failure
_____ Heart Murmur
_____ Hepatitis
_____ High Blood Pressure
_____ High Cholesterol
_____ Hives
_____ Irregular Heartbeat/Skipped Beats
_____ Jaundice
_____ Kidney Stones
_____ Lasik Eye Surgery
_____ Macular Degeneration
_____ Melanoma Skin Cancer
_____ Rheumatic Fever
_____ Skin Cancer (other types)
_____ Sickle Cell
_____ Skin Disease
_____ Sleep Apnea Diagnosis
_____ Snoring
_____ Have you used CPAP?
_____ Stroke
_____ Thyroid Disorder
_____ Tuberculosis
_____ Ulcers
_____ Urinary Tract Infection
_____ Radiation Treatment

Patient's Medical History (check all that apply)

Other medical condition not listed above:

_____

_____

_____

Doctor: _____
Chart #: _____ **Allergy/Allergies Alert**
Previous Surgeries

Surgery: _____ Date: _____ Reason: _____
Surgery: _____ Date: _____ Reason: _____
Surgery: _____ Date: _____ Reason: _____
Surgery: _____ Date: _____ Reason: _____
Surgery: _____ Date: _____ Reason: _____
Surgery: _____ Date: _____ Reason: _____
Surgery: _____ Date: _____ Reason: _____
Surgery: _____ Date: _____ Reason: _____
Surgery: _____ Date: _____ Reason: _____
Surgery: _____ Date: _____ Reason: _____

Do you have a family history of? (Please circle answer)

Abnormal Bleeding	Yes	No	If Yes, who: _____
Blood Clotting	Yes	No	If Yes, who: _____
Anesthesia Problems	Yes	No	If Yes, who: _____
Autoimmune Disorders	Yes	No	If Yes, who: _____
Breast Cancer	Yes	No	If Yes, who: _____
Malignant Hyperthermia	Yes	No	If Yes, who: _____
Melanoma	Yes	No	If Yes, who: _____
Ovarian Cancer	Yes	No	If Yes, who: _____
Other: _____	Yes	No	If Yes, who: _____

Blood Clot (DVT/PE) Assessment/Risk (Please check all that apply.)

_____ Past History of Blood Clots (location of clots: _____)
_____ Family History of Blood Clots
_____ Swollen Legs
_____ Varicose Veins
_____ Past Illness of Heart, Liver, Lung, or Gastrointestinal Tract
_____ Do you take birth control pills?

Social History

Smoking	Current	Former	Never Smoker	Tobacco chewer	Frequency:
Alcohol	Yes	No			
	Frequency:		Socially	Daily	History of Alcoholism
Recreational Drugs	Yes	No			History of Drug Abuse

Patient Ability to Heal

Does your skin appear fragile, burns easily?	Yes	No
Do you form thick or raised scarring from a cut or burn?	Yes	No
Do you wax or use depilatories on your face?	Yes	No
Do you ever get cold sores?	Yes	No

Doctor: _____
Chart #: _____ **Allergy/Allergies Alert**
When was your last mammogram? Date: _____

Do you have regular periods?	Yes	No
Are you going through menopause?	Yes	No
Are you pregnant or lactating?	Yes	No
During pregnancy, did you ever get hyperpigmentation or masking?	Yes	No

When was your last flu shot? Date: _____ Circle: By Work By Hospital By School On Own

Allergies and Medications

Do you have a latex allergy**?** YES or NO

Do you have any drug allergies? YES or NO

List ALL medications you are allergic to:

_____

_____

Pain medications you CANNOT tolerate: _____

Are you on aspirin/blood thinners? YES or NO If Yes, please state: _____

Do you take vitamins? _____ Do you take Vitamin E? _____

Do you use herbal supplements? YES or NO

Current Medications:

Drug: _____ Dose: _____ How taken? _____
Drug: _____ Dose: _____ How taken? _____
Drug: _____ Dose: _____ How taken? _____
Drug: _____ Dose: _____ How taken? _____
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Drug: _____ Dose: _____ How taken? _____
Drug: _____ Dose: _____ How taken? _____

Patient Signature: _____Date_____

FOR STAFF USE ONLY

Vitals

BP: _____ Pulse: _____ Respiration Rate: _____ Temperature: _____