RICHMOND
PLASTIC SURGEONS

Plastic Surgery Health Information Form

Date: _____ Name: _____ Male or Female

Birthdate: _____/_____/_____ Age: _____ Height: _____ ft _____in Weight: _____

Reason for Visit: _____

Pharmacy Name: _____ Pharmacy phone #:_____

Pharmacy Address: _____

Referring Doctor: _____

Patient's Medical History (check all that apply)

_____ Anxiety
_____Anesthesia Problems
_____ Asthma
_____ Bleeding Disorder
_____ Blindness
_____ Blood Clots
_____ Breast Cancer
_____ Bronchitis
_____ Cancer
_____ Chest Pain/Tightness
_____ Cold Sores
_____ 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
_____ Gastrointestinal Problems
_____ Genitourinary
_____ Glaucoma
_____ Heart Attack (MI)
_____ Heart Failure
_____ Heart Murmur
_____ Heart Problems
_____ Hepatitis
_____ High Blood Pressure
_____ High Cholesterol
_____ Hives
_____ Irregular Heartbeat/Skipped Beats
_____ Jaundice
_____ Kidney Stones
_____ Lasik Eye Surgery
_____ Lung Problems
_____ Macular Degeneration
_____ Melanoma Skin Cancer
_____ Rheumatic Fever
_____ Skin Cancer (other types)
_____ Sickle Cell
_____ Skin Disease
_____ Sleep Apnea Diagnosis
_____ Snoring
_____ Have you used CPAP?
_____ Stroke
_____ Swollen Legs
_____ Thyroid Disorder
_____ Tuberculosis
_____ Ulcers
_____ Urinary Tract Infection
_____ Varicose Veins
_____ Radiation Treatment

Other medical condition not listed above:
_____
_____

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: _____
Abnormal 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: _____

Social History

Alcohol	☐ Yes	☐ No	**Frequency:**	☐ Socially ☐ Daily	☐ History of Alcoholism
Smoking	☐ Current **Frequency:**	☐ Former	☐ Never Smoker	☐ Tobacco chewer	☐ E-Cigarettes/Vaping
Recreational Drugs	☐ Yes	☐ No	☐ History of Drug Abuse		

Female Questions

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 mammogram? Date: _____		
Current bra size? _____		

Allergies and Medications

Last Flu Shot Date: _____ **Circle:** By Work			By Hospital By School On Own
Pneumonia Vaccination	☐Yes	☐No	
Latex allergy?	☐Yes	☐No	
Drug allergies?	☐Yes	☐No	If Yes, list:
Do you take aspirin/blood Thinner?	☐Yes	☐No	If Yes, list:
Do you take vitamins/herbal supplements?	☐Yes	☐No	If Yes, list:

Current Medications and Vitamins/Supplements:

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

Patient Signature: _____Date_____