

Artisan Plastic Surgery, LLC
Patient Medical History

Date: _____

Confidential Information: Information contained herein will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. Your doctor will use the information that you provide her decisions regarding your care.

PATIENT INFORMATION:

Patient's Name: _____ DOB: ____/____/____ Age: _____
Height: _____ Weight _____ Sex: M ___ F ___

PHYSICIAN INFORMATION (Please give full names):

Referring Physician: _____ Address: _____
Family Physician: _____ Address: _____
OB-GYN: _____ Address: _____
Breast Surgeon: _____ Address: _____
Oncologist: _____ Address: _____
Send Correspondence to: _____ Address: _____

MEDICAL INFORMATION: Do you have or have you had: (if yes, give date of occurrence):

AIDS or HIV+	No ___ Yes ___	Arthritis	No ___ Yes ___
Asthma	No ___ Yes ___	Back Problems	No ___ Yes ___
Bladder Infection	No ___ Yes ___	Bleeding Tendency	No ___ Yes ___
Bronchitis	No ___ Yes ___	Cancer	No ___ Yes ___
Colitis	No ___ Yes ___	Congenital Heart	No ___ Yes ___
Diabetes	No ___ Yes ___	Epilepsy	No ___ Yes ___
Hepatitis	No ___ Yes ___	High Blood Pressure	No ___ Yes ___
Kidney Disease	No ___ Yes ___	Heart Disease	No ___ Yes ___
Migraine	No ___ Yes ___	Pneumonia	No ___ Yes ___
Stomach Ulcer	No ___ Yes ___	Thyroid Disease	No ___ Yes ___
Stroke	No ___ Yes ___	Tuberculosis	No ___ Yes ___

Other serious illnesses that you have had: _____

Do you smoke? Y ___ N ___ How much per week? _____ For how many years? _____

Do you regularly drink alcohol? Y ___ N ___ How much? _____

How many pregnancies? _____

How many children? _____

Have you ever had any complications from anesthesia? No ___ Yes ___

Please list any medications (prescription, over-the-counter) that you have taken within the last month, the name and year of any surgeries that you have had, any drugs to which you are allergic, and any serious injuries or accidents you may have had.

Last Pap smear: _____

Results: _____

Last Mammogram: _____

Results: _____

Allergies (Please do not leave blank):

Previous Surgeries:

List of Medications: