

MONMOUTH PLASTIC SURGERY
PATIENT HEALTH HISTORY

HEIGHT _____ WEIGHT _____

ALLERGIES TO DRUGS: _____

TAPE: _____ LATEX: _____

CURRENT MEDICATIONS: _____

VITAMINS: _____

HERBAL MEDICATION / DIET PILLS: _____

DO YOU TAKE MOTRIN, ADVIL OR ASPIRIN REGULARLY? Y/N

LAST TETANUS SHOT _____ - _____ - _____

ARE YOU CURRENTLY OR HAVE YOU EVER BEEN TREATED FOR:

ASTHMA	Y/N	DIABETES	Y/N	HIGH BLOOD PRESSURE	Y/N
STROKE	Y/N	CANCER	Y/N	TYPE _____	
HEART DISEASE	Y/N	INTESTINAL	Y/N	THYROID	Y/N
VASCULAR	Y/N	BLOOD D/O	Y/N	HEPATITIS	Y/N
HIV	Y/N	SKIN DISORDER	Y/N		
NEUROLOGICAL DISEASE	(MS, Myasthenia Gravis, etc)		Y/N		

Do you have bleeding disorders or do you bruise easily? _____
Have you ever used anabolic steroids or growth hormone? Y / N

SURGICAL HISTORY - PLEASE LIST ALL PREVIOUS OPERATIONS AND YEAR

TOBACCO USE Y / N

Cigarettes / Packs per day? _____
What year did you start smoking? _____

ALCOHOL USE Y / N

Frequency: Daily _____ Weekends _____ Rarely _____

FAMILY HISTORY

Cancer _____ Collagen / Vascular Disease _____ Melanoma _____
Hypertension _____ Skin Cancer _____ Other _____

BREAST HISTORY

LAST MAMMOGRAM _____ - _____ - _____ RESULT _____
Lumps/masses? _____ Nipple discharge? Y / N
Is there a family history of breast cancer? Y / N
Relation to patient: _____
Current breast cup size (if applicable): 30-32-34-36-38-40 A B C D DD DDD

REASON FOR TODAY'S VISIT: _____

IS TODAY'S VISIT A COSMETIC CONSULTATION Y / N

Please list the specific areas you would like addressed in your consultation:

How did you hear about us?

Friend _____ Phone book _____ Newspaper _____ Television _____
Facebook _____ Hospital Referral _____ Physician _____ Internet _____
Please list the name of your referral (optional) _____
