
# Medical History and Physical

**Name:**_____ **Date:**_____

**Primary Care Physician:**_____ **(Phone):**_____ **Date Last Seen:**_____

**What Procedure are you interested in?** _____

**Have you had Cosmetic Surgery in the past?** ○Y ○N

Procedure: _____ Physician: _____ Date: _____

Complications: _____

Procedure: _____ Physician: _____ Date: _____

Complications: _____

**Please list all other Surgeries with the Physicians name, the date, and the hospital:**

_____

_____

_____

**Indicate the Type(s) of anesthesia received in the past. List any complications/reactions you experienced:**

Local Anesthesia: Complication/Reaction: _____

General Anesthesia: Complication/Reaction: _____

Spinal/Epidural: Complication/Reaction: _____

***Do you have any known Drug Allergies:** ○ Y ○ N **Latex Allergy:** ○ Y ○ N **Tape Allergy:** ○ Y ○ N

Drug:_____

***Preferred Pharmacy Information:**_____

***For Women:**

Number of Pregnancies: _____ Number of Children: _____ Did you Breast Feed? ○Y ○N If so, How Long? _____ Last Period: _____

***Date of Last Mammogram**: _____ Results: _____ Current Bra Size: _____

***Current Medications**

| Medication | Dose | Frequency |
|---|---|---|
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Regular Aspirin Use?: ○ Y ○ N Dosage & Frequency: _____

Regular NSA use? (Advil, Motrin, and Ibuprofen): ○ Y ○ N Dosage & Frequency: _____

**Non-Prescription (Vitamins; Herbs)**

_____

**SOCIAL HABITS**

Smoke: ○ Y ○ N Amount: _____ Coffee/Tea/Soda: ○ Y ○ N Amount: _____

Alcohol: ○ Y ○ N Amount: _____ Daily Exercise: ○ Y ○ N Amount:_____

**Personal History:** Have you ever had any of the following?

Abnormal Bleeding: ○ Y ○ N Asthma: ○ Y ○ N Hypertension: ○ Y ○ N

Abnormal Clotting: ○ Y ○ N Diabetes: ○ Y ○ N Sleep Apnea: ○ Y ○ N

Acid Regurgitation: ○ Y ○ N Fainting Spell: ○ Y ○ N Snoring: ○ Y ○ N

Anemia: ○ Y ○ N Heart Attack: ○ Y ○ N Hepatitis: ○ Y ○ N

Angina: ○ Y ○ N Weight Change in past year: ○ Y ○ N Other Illness: ○ Y ○ N

**Please describe questions with "Yes" answer:**

_____

Have you ever received a Transfusion? ○ Y ○ N If Yes explain: _____

Have you ever been tested for HIV? ○ Y ○ N If Yes, What year_____ Test results: ○ Pos ○ Neg

Do you wear: Contact Lenses: ○ Y ○ N Eye Glasses: ○ Y ○ N Hearing Aid: ○ Y ○ N Dentures: ○ Y ○ N

**Family History:** Have any blood relatives ever had any of the following?

Abnormal Bleeding: ○ Y ○ N Coronary Surgery: ○ Y ○ N Kidney Disease: ○ Y ○ N

Abnormal Clotting: ○ Y ○ N Diabetes: ○ Y ○ N Tuberculosis: ○ Y ○ N

Anesthetic Problems: ○ Y ○ N Heart Attack: ○ Y ○ N Other Illness: ○ Y ○ N

Cancer: ○ Y ○ N Hypertension: ○ Y ○ N

Please describe questions with "Yes" answer: _____

**Authorization for Disclosure of Information**

I authorize Grotting & Cohn Plastic Surgery to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment to those individuals who, in Grotting & Cohn Plastic Surgery's sole determination, are required to receive such information *for the purpose of medical treatment, medical quality assurance and peer review.*

**Patient Signature:** _____ **Date:** _____