Welcome to our Reconstructive and Aesthetic Plastic Surgery Office

Please fill out the following form. *All information is protected and confidential.*

Thank you!

Date: _____ Age: _____

Name: _____

How did you hear about us? _____

(Be specific as we would like to thank them!)

Reason for today's visit: (Please be as specific as possible) _____

_____

_____

_____

MEDICAL INFORMATION:

Our goal is to help you. Please answer as truthfully and completely as possible.

Do you have any allergies to food or medication? Yes No

Allergy: What Happens?:

_____

_____

_____

Do you take any anti-depressant medication? Yes No

List: Prescribed by:

_____

Please list all medications, vitamins, herbal supplements that you are taking:

_____ _____

_____ _____

_____ _____

_____ _____

Date of last Physical Exam: _____

E-Mail address: _____

Would you like to be added to our emailing list? Yes No

St.JosephHealth

St. Jude Heritage Medical Group

_____

_____

Do you have or have a history of:

Heart Disease	___Yes ___No	Bulimia or Anorexia	___Yes ___No
Autoimmune Disorder	___Yes ___No	Chronic Illness	___Yes ___No
Asthma	___Yes ___No	Mental Illness	___Yes ___No
Drug Dependency	___Yes ___No	Blood Clotting Disorder	___Yes ___No
Anemia	___Yes ___No	Depression	___Yes ___No
Lung Disease	___Yes ___No	High Blood Pressure	___Yes ___No
Blood Disorders	___Yes ___No	Cancer	___Yes ___No
Serious Accident	___Yes ___No	Diabetes	___Yes ___No
Birth Control Usage	___Yes ___No	Sleep Apnea	___Yes ___No
If yes, Type: _____		CPAP Machine	___Yes ___No
Latex Allergy:	___Yes ___No	Environmental Allergy	___Yes ___No

Other: _____

If you answered yes to any of the above, please explain:

_____

_____

_____

_____

List all previous Surgeries:

Type: _____ Date: _____ Performed by: _____
Type: _____ Date: _____ Performed by: _____
Type: _____ Date: _____ Performed by: _____
Type: _____ Date: _____ Performed by: _____
Type: _____ Date: _____ Performed by: _____

Have you had any cosmetic plastic surgery procedures? Yes No
Were you pleased with the outcome? Yes No

Do you have family history of:

Skin Cancer	___Yes ___No	Diabetes	___Yes ___No
Cancer	___Yes ___No	Arthritis	___Yes ___No
Heart Disease	___Yes ___No	Headache	___Yes ___No
Congestive Heart Failure	___Yes ___No	Stroke	___Yes ___No
Hypertension	___Yes ___No	Alcoholism	___Yes ___No
Kidney Disease	___Yes ___No	Mental Illness	___Yes ___No
Asthma	___Yes ___No	Coronary Artery Disease	___Yes ___No
Emphysema	___Yes ___No	Uterine Cancer	___Yes ___No
Crohn's Disease	___Yes ___No	Ovarian Cancer	___Yes ___No
Hepatic Disorders	___Yes ___No	Breast Cancer	___Yes ___No
Hyperlipidemia	___Yes ___No	Colon Cancer	___Yes ___No
Thyroid Disorder	___Yes ___No	Tendency for easily bruising	___Yes ___No
Osteoporosis	___Yes ___No	Skin wounds slow to heal	___Yes ___No

CHILDBIRTH: (If applicable)

Number of Pregnancies? _____ Amount of weight gain with each pregnancy? _____

Number of children? _____ Age(s) of children? _____

Did you breastfeed? Yes / No

If Yes, how long?_____

LIFESTYLE:

Single / Married / Divorced / Widowed / Other

Do you smoke? Yes / No Packs per day? _____

Number of Years _____

If you quit, when? _____

How many drinks containing alcohol do you drink per week?

_____

Do you take Aspirin or Ibuprofen on a regular basis? Yes / No

Are you on a diet pll or diet program now? Yes / No

Do you take vitamins regularly? Yes / No

Height: _____ Weight_____

Do you exercise? Yes / No Activity: _____

How Often? _____

Are you able to walk up a flight of stairs, walk up a hill or do heavy housework WITHOUT having chest pain or shortness of breath? Yes / No

If "No" explain why:

_____

_____