Patient Name ______________________________ Date: ______________

MATERNAL HISTORY

Have you ever been pregnant? Yes No If yes, how many times? ______________

How many children do you have? ______________ Are you now pregnant? ______________

GENERAL

Height ______________ Present Weight ______________

Do you smoke? Yes No If yes, how much? ______________

How much alcohol do you drink per week? ______________

Are you allergic to pills, drugs, or medicine? Yes No Latex Allergy? Yes No

If yes, please list: ______________

Please list all medications you are now taking (including vitamins and non-prescription drugs)

____

____

Approximate date of last normal pelvic or rectal exam ______________

Have you ever had a Reaction to a GENERAL anesthetic? (Being put to sleep)	Yes	No
Have you ever had a Reaction to a LOCAL anesthetic? (Example Novocaine etc.)	Yes	No
Do you have high blood pressure?	Yes	No
Do you form heavy scars?	Yes	No
Do you have frequent infections or boils?	Yes	No
Have you ever had any excessive bleeding problems?	Yes	No
Have you ever had any significant emotional problems?	Yes	No
Have you ever been advised or had psychiatric care?	Yes	No
Have you seen other plastic surgeons about the SAME problem which brings you here?	Yes	No

____

LOCAL PROBLEMS

Have you had any serious illnesses of the following? (Circle if Yes)

Brain	Nose	Heart	Bleeding problems	Extremities
Eyes	Breasts	Abdomen	Reproduction	Endocrine (Diabetes)
Ears	Lungs	Urinary	Nervous	Other

If circled, please explain: ______________

____

PREVIOUS SURGERY (Please List)

Operation Year Complication, if any

____

____

Serious Injuries

Type Year

____

____

SIGNATURE ______________________________

Relationship to Patient (Self, Mother, etc.) ______________