THE PLASTIC SURGERY GROUP OF ROCHESTER, LLC

Please answer all questions below to the best of your knowledge. The information provided by you will be used by your doctor in decisions regarding your care. This information will not be released without a written authorization from you.

Right_____Left_____ Hand Dominant

Name: _____ Age: _____ Sex: M F
Primary Care Physician:_____Date:_____
Reason for today's visit:_____

DO YOU NOW HAVE, OR HAVE YOU HAD: (circle yes or no, and give approximate date if yes)

		Date
General		
Unexplained weight loss	Yes _____ No	
Unexplained fever	Yes _____ No	
Other_____		
Cardiac		
High blood pressure	Yes _____ No	
Heart failure	Yes _____ No	
Heart attack	Yes _____ No	
Mitral valve prolapse	Yes _____ No	
Other heart murmur	Yes _____ No	
High cholesterol	Yes _____ No	
Angina	Yes _____ No	
Peripheral vascular disease	Yes _____ No	
Pulmonary		
Tuberculosis	Yes _____ No	
Emphysema	Yes _____ No	
Asthma	Yes _____ No	
Endocrine		
Diabetes	Yes _____ No	
Diabetes (taking insulin)	Yes _____ No	
Thyroid disorder	Yes _____ No	
Neurological		
Stroke	Yes _____ No	
Seizures	Yes _____ No	
Musculoskeletel		
Arthritis	Yes _____ No	
Tendonitis	Yes _____ No	
where_____		
Other		
Cancer	Yes _____ No	
where_____		
Leukemia	Yes _____ No	
Bleeding tendency	Yes _____ No	
HIV/AIDS	Yes _____ No	
Stomach ulcers	Yes _____ No	
Hepatitis A, B, or C	Yes _____ No	
(please circle A,B, or C, above)		
Depression	Yes _____ No	
Anxiety	Yes _____ No	
Other_____		

List all medications and dosages:

_____ _____
_____ _____
_____ _____

Do you have allergies to any medications? No_____ Yes_____ **LATEX ALLERGY ?** _____
If yes, please list: _____
Do you have allergies to any thing else? _____
List any operation you have had and the year it was done: _____
_____ _____
_____ _____

List other serious injuries/accidents you have had: _____
_____

SOCIAL HISTORY

Do you smoke now? No_____Yes _____How much? _____How long? _____
Did you smoke in the past? No____Yes____How much? _____ For how long?_____When did you quit_____.
Do you regularly drink (circle) alcohol, beer, or wine? No____ Yes_____ How much? _____

Has any family member ever had: (parent, sibling, or grandparent)

	Yes	No	Relationship		Yes	No	Relation
Cancer				Diabetes			
Kidney Disease				Thyroid disease			
Heart Disease				Seizure Disorder			
High Blood Pressure				Stroke			
Arthritis				High cholesterol			
Stomach Disease				Asthma			
Tuberculosis				Drug/Alcohol Abuse			

HEIGHT _____ WEIGHT_____

Women only:

Any chance you are pregnant? No_____ Yes_____

Have you had a mammogram? No_____ Yes_____
If yes – date/location_____

Above information has been reviewed with patient.

Doctor:_____ Date:_____
Physician's signature

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