Carolina Plastic Surgery, P.A.

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HISTORY & PHYSICAL FORM

Today's Date: _______________ Referred By: _______________________

Patient Name: ________________________________ Age: __________

Reason for today's visit /brief history:

____

____

MEDICAL HISTORY:

1. **Previous or current medical problems:**
   ____
   ____
   ____
   ____
   ____

2. **Do you have or have you ever had any form of hepatitis or HIV? Yes or No**

3. **Allergies to Medications: ____**

   Allergies to Food (s): ____

4. **Are you allergic to iodine (shellfish, IVP dye for kidney x-rays /dye for arteriogram) Yes NO**

   A. Are you allergic to latex (natural rubber, bananas, and kiwi)? Yes No

5. **Medications you take regularly or occasionally:**

   ___________________________ ___________________________

   ___________________________ ___________________________

   ___________________________ ___________________________

   ___________________________ ___________________________

6. **Do you ever take diuretic (water pills) Yes No**

7. **Do you bruise easily? Yes No**

A. **Have you ever had problems with bleeding during surgery? Yes or No**

B. **Do you ever take aspirin products, such as Goody or BC Powder, Motrin, Advil Nuprin, Ibuprofen, Naprosyn, Anaprox, Other: __________________ or any on the list of products and medications included in your packet?**

If yes, please list: ____
____

C. **Do you take vitamins and/or herbs (Fever Few, Green Tea, Ginko Biloba, W*ill*ow *Bark,* Vitamin A, Vitamin E etc.? If yes, please list:**
____
____

8. **Past surgical procedure and or hospitalizations (include dates):**
____
____
____
____

Have you had any anesthesia –related problems during or after surgery? Yes or No

9. **Have you or a family member ever had a high fever during or immediately after surgery? Yes or No If yes, explain:____**

10. **Does anyone in your family have a history of malignant hyperthermia? Yes No Is yes explain: ____**

11. **Do you have a high temperature/fever after exercising? Yes No**

12. **<u>FAMILY HISTORY:</u>**

Has anyone in your family had any of the following?

Heart Disease? Yes No Who? ______________________

High Blood Pressure? Yes No Who? ______________________

Cancer? Yes No Who? ______________________

Addiction? Yes No Who? ______________________

Diabetes? Yes No Who? ______________________

13. **<u>EENT:</u>**

Do you have problems with your eyes, ears, nose, or throat? YES NO

If yes explain: ____

14. Do you Smoke? Yes No (how many packs per day and for how long) ______PPD ____Years

Does your spouse, significant other or anyone in your household smoke? Yes or No

<u>Cardiovascular:</u>

15. Do you have problems with your heart? YES NO (chest pain, heart attack, high blood pressure, heart murmur) If yes, explain: ________________________________

Date of last physical examination: ____

Date last Electrocardiogram performed? ________________________

Do you ever get short of breath? Yes No

Do your ankles swell? Yes No

16. <u>GI:</u>

Do you have problems with ulcers? Yes No

Have you ever vomited blood? Yes No

Have you ever passed blood in your stool? Yes No

Do you have diabetes? Yes No

Have you had gallbladder trouble? Yes No

Have you ever had yellow jaundice? Yes No

17. <u>GU:</u>

Have you ever had any trouble with kidney stones? Yes No

Have you ever had any trouble with kidney infections? Yes No

Do you have trouble with bladder infections? Yes No

Men: do you have prostate trouble? Yes No

Women: Are your periods regular? Yes No

Any excessive bleeding? Yes No

Are you pregnant? Yes No

18. <u>Neuromuscular</u>:

Do you have seizures? Yes No

Have you ever had a stroke? Yes No

19. <u>Miscellaneous</u>:

Have you ever had blood clots in your legs (phlebitis)? Yes No

Have you ever had blood clots in your lungs (Pulmonary embolus)? Yes or No

20. Do you have any history or have you ever been told that you have any anxiety disorder?
    Yes No (Panic/anxiety attacks, obsessive compulsive disorder, body dysmorphic disorder?)

21. Do you have sickle cell anemia? Yes No

22. Do you currently have any dental problems (loose tooth, periodontal disease)? Yes No

If yes explain: ____

A. Have you recently had any dental procedures? Yes No

If yes, explain:____

23. DO YOU HAVE OR HAVE YOU HAD ANY MEDICAL PROBLEMS THAT I HAVE NOT ASKED YOU ABOUT?

If yes, explain: ____

AN HONEST ANSWER TO THE FOLLOWING QUSTIONS ARE ABSOLUTELY CRUICIAL FOR YOUR SAFTEY DURING ANESTHESIA

Do you drink Alcohol? Yes or No How often? _____________ How much? _________

Do you or have you ever used illegal street drugs? Yes No

If yes explain: ____

"The above information is correct and complete to the best of my knowledge."

** For Nurse**

Bp: ___________ Patient Signature: ___________________________

Pulse: ___________

Height: ___________ Physician's Signature: _________________________

Weight: __________

Checked By: ___________