San Antonio Plastic Surgery Institute Medical History

** PLEASE PRINT **

NAME: _____
DATE: _____

REASON FOR TODAY'S VISIT:
_____
_____

DO YOU HAVE ANY GENERAL HEALTH PROBLEMS? YES ( ) NO ( )
IF YES EXPLAIN:
_____
_____

ARE YOU TAKING ANY MEDICATIONS (INCLUDING ASPIRIN OR OVER THE COUNTER DRUGS)? YES ( ) NO ( )
IF YES, LIST:
_____
_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ( ) NO ( )
IF YES, LIST:
_____
_____

LIST ANY PREVIOUS SURGERIES:
_____
_____

ARE YOU PREGNANT? YES ( ) NO ( )
IF NO, DATE OF LAST MENSTRUAL PERIOD:
_____

DO YOU DRINK ALCOHOL? YES ( ) NO ( )
IF YES, HOW MANY DRINKS A WEEK?
_____

DO YOU SMOKE? YES ( ) NO ( )
IF YOU HAVE EVER SMOKED, WHEN DID YOU STOP?
_____

HOW MANY PACKS A DAY? _____

DO YOU HAVE ANY DRUG PROBLEMS OR ADDICTIONS?
_____

HISTORY OF BREAST CANCER? YES ( ) NO ( )
LAST MAMMOGRAM?
_____

HAVE YOU OR ANYONE IN YOUR FAMILY EVER HAD PROBLEMS WITH A GENERAL ANESTHETIC?
IF SO, WHAT OCCURRED?
_____
_____

DO YOU NOW HAVE OR HAVE YOU EVER HAD:

- HEART DISEASE _____ DIABETES _____
- HIGH BLOOD PRESSURE_____ CANCER _____
- LUNG PROBLEMS _____ ARTHRITIS _____
- BLEEDING DISORDER _____ STROKE _____
- INTESTINAL DISEASE _____ EPILEPSY _____
- HEPATITIS _____ DEPRESSION _____
- HIV/AIDS _____ ANXIETY ATTACKS _____
- TUBERCULOSIS _____ ABNORMAL HEALING _____