



BARBER CENTER

for PLASTIC SURGERY

1591 Yanceyville Street, Suite 100

Greensboro, NC 27405

336-275-3430

www.barberplasticsurgery.com

Date: _____

Name: _____ Age: _____ DOB: _____

Race: Caucasian African American Hispanic American Indian Other _____

For what reason are you seeing Dr. Barber today? _____

MEDICAL HISTORY

Have you ever had any of the following conditions:

	Yes	No		Yes	No
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Angina (chest pain)	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding (tendency)	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Recent weight gain/loss (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Blurred/double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Breast Lump	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Confusion	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Bi-Polar Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>
High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>

PAST SURGICAL HISTORY: (List all previous surgeries.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

FAMILY HISTORY: Do you have a family history of any of the following:

- | | | | |
|----------------------------------------|------------|----------------------------------------------|------------|
| <input type="checkbox"/> Heart Attacks | Who: _____ | <input type="checkbox"/> Diabetes | Who: _____ |
| <input type="checkbox"/> Breast Cancer | Who: _____ | <input type="checkbox"/> Alcoholism | |
| <input type="checkbox"/> Other Cancer | Who: _____ | <input type="checkbox"/> Psychiatric Disease | |
| <input type="checkbox"/> Obesity | | <input type="checkbox"/> High Blood Pressure | |

ALLERGIES: Do you have Allergies to:

- | | | | |
|---------------|------------------------------|-----------------------------|-------------|
| Medicines | <input type="checkbox"/> Yes | <input type="checkbox"/> No | List: _____ |
| Food | <input type="checkbox"/> Yes | <input type="checkbox"/> No | List: _____ |
| Environmental | <input type="checkbox"/> Yes | <input type="checkbox"/> No | List: _____ |

MEDICATIONS: Please list all medications that you are taking, including dosage and frequency. Also, list over-the-counter medications and Herbals.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**REVIEW OF SYSTEMS
CONSTITUTIONAL**

- | | Yes | No |
|----------------------|--------------------------|--------------------------|
| Recent weight change | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> |

EYES

- | | | |
|-----------------------|--------------------------|--------------------------|
| Loss of vision | <input type="checkbox"/> | <input type="checkbox"/> |
| Wear glasses/contacts | <input type="checkbox"/> | <input type="checkbox"/> |
| Double/Blurred Vision | <input type="checkbox"/> | <input type="checkbox"/> |

HEART

- | | | |
|------------------|--------------------------|--------------------------|
| Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Palpitations | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling of legs | <input type="checkbox"/> | <input type="checkbox"/> |

EARS/NOSE/THROAT

- | | Yes | No |
|---------------|--------------------------|--------------------------|
| Sore Throat | <input type="checkbox"/> | <input type="checkbox"/> |
| Hoarseness | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding gums | <input type="checkbox"/> | <input type="checkbox"/> |

BREAST

- | | | |
|------------------|--------------------------|--------------------------|
| Lumps | <input type="checkbox"/> | <input type="checkbox"/> |
| Nipple discharge | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |

	Yes	No
RESPIRATORY	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Sputum	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
GENITOURINARY		
Frequency at night	<input type="checkbox"/>	<input type="checkbox"/>
Burning with urination	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
SKIN		
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancers	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
GI		
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
MUSCULOSKELETAL		
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
PSYCHIATRIC		
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Sadness	<input type="checkbox"/>	<input type="checkbox"/>
Frequent crying	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts of suicide	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Have you ever had a bad reaction associated with being put to sleep for surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Has a family member had a bad reaction when being put to sleep for surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to adhesive tape or any kind of tape?	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to any types of suture material?	<input type="checkbox"/>	<input type="checkbox"/>
Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a slow or poor healer?	<input type="checkbox"/>	<input type="checkbox"/>
Do you form bad scars or keloids?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent skin infections or boils?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken steroid medication?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you ever had any significant emotional problems?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been under the care of a psychiatrist or psychologist?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been under the care of any doctor for emotional problems?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you considering a pregnancy in the future?	<input type="checkbox"/>	<input type="checkbox"/>
Is there anything about your medical history that you feel that I should know?	<input type="checkbox"/>	<input type="checkbox"/>

Sign

Date