BARBER CENTER
for PLASTIC SURGERY

MEDICAL HISTORY FORM

Name : _____ Age:_____ DOB:_____

Race: ❑ Caucasian ❑ African American ❑ Hispanic ❑ American Indian ❑ Asian ❑ 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	❑	❑	High Blood Pressure	❑	❑
Anemia	❑	❑	Kidney Disease	❑	❑
Angina (chest pain)	❑	❑	Migraine Headaches	❑	❑
Asthma	❑	❑	Mitral Valve Prolapse	❑	❑
Back Pain	❑	❑	Recent weight gain/loss (circle)	❑	❑
Bleeding (tendency)	❑	❑	Stroke	❑	❑
Blood Transfusion	❑	❑	Thyroid Disease	❑	❑
Blurred/Double Vision	❑	❑	Venereal Disease	❑	❑
Breast Lump	❑	❑	Memory Loss	❑	❑
Cancer	❑	❑	Confusion	❑	❑
Diabetes	❑	❑	Depression	❑	❑
Dry Eyes	❑	❑	Bi-polar Disorder	❑	❑
Epilepsy	❑	❑	Alcoholism	❑	❑
Emphysema	❑	❑	Tobacco use	❑	❑
Glaucoma	❑	❑	Drug Abuse	❑	❑
Heart Disease	❑	❑	Hepatitis	❑	❑

PAST SURGICAL HISTORY: (List all previous surgeries)

1. _____ **4.** _____

2. _____ **5.** _____

3. _____ **6.** _____

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

❑ Heart Attacks Who:_____ ❑ Diabetes Who:_____

❑ Breast Cancer Who:_____ ❑ Alcoholism Who:_____

❑ Other Cancer Who:_____ ❑ Psychiatric Disease Who:_____

❑ Obesity Who:_____ ❑ High Blood Pressure Who:_____

SOCIAL HISTORY:

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Tobacco Use: ❑ Cigarettes packs/day_____ ❑ Other Tobacco _____

Alcohol: ❑ Yes ❑ No How much: _____

ALLERGIES: Do you have allergies to:

Medicines: ❑ Yes ❑ No List:_____

Food: ❑ Yes ❑ No List:_____

Enviromental: ❑ Yes ❑ 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	❑	❑
Fatigue	❑	❑
Headaches	❑	❑
EYES		
Loss of vision	❑	❑
Wear glasses/contacts	❑	❑
Double/Blurred Vision	❑	❑
HEART		
Chest Pain	❑	❑
Palpitations	❑	❑
Swelling of legs	❑	❑
RESPIRATORY		
Shortness of Breath	❑	❑
Wheezing	❑	❑
Cough	❑	❑
Blood in Sputum	❑	❑
GENITOURINARY		
Frequency at night	❑	❑
Burning with urination	❑	❑

EARS/NOSE/THROAT	YES	NO
Sore Throat	❑	❑
Hoarseness	❑	❑
Bleeding Gums	❑	❑
BREAST		
Lumps	❑	❑
Nipple discharge	❑	❑
Cancer	❑	❑
SKIN		
Eczema	❑	❑
Skin Cancers	❑	❑
GI		
Diarrhea	❑	❑
Constipation	❑	❑
Blood in stool	❑	❑
Hiatal Hernia	❑	❑
MUSCULOSKELETAL		
Back Pain	❑	❑
Joint Pain	❑	❑
Cold Extremities	❑	❑

	YES	NO
Have you ever had a bad reaction associated with being put to sleep for surgery?	❑	❑
Has a family member had a bad reaction when being put to sleep for surgery?	❑	❑
Are you allergic to adhesive tape or any kind of tape?	❑	❑
Do you bruise easily?	❑	❑
Do you form bad scars or keloids?	❑	❑
Do you have frequent skin infections or boils?	❑	❑
Have you ever taken steriod medication?	❑	❑
Do you have or have you ever had any significant emotional problems?	❑	❑
Have you ever been under the care of a psychiatrist or psychologist?	❑	❑
Have you ever been under the care of any doctor for emotional problems?	❑	❑
Are you pregnant?	❑	❑
Are you considering a pregnancy in the future?	❑	❑
Is there anything about your medical history that you feel that I should know?	❑	❑

_____ _____

Sign Date