BARBERCENTER
for PLASTIC SURGERY

Medical History Form

Official Use Only
Height _____
Weight _____

Name _____ Age _____ Date of Birth _____

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?*

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Angina *(chest pain)*
- ☐ Asthma
- ☐ Back Pain
- ☐ Bleeding *(tendency)*
- ☐ Blood Transfusion
- ☐ Blurred/Double Vision
- ☐ Breast Lump
- ☐ Cancer
- ☐ Diabetes
- ☐ Dry Eyes
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Recent Weight ○ Gain *or* ○ Loss
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Venereal Disease
- ☐ Memory Loss
- ☐ Confusion
- ☐ Depression
- ☐ Bi-polar Disorder
- ☐ Alcoholism
- ☐ Tobacco Use
- ☐ Drug Abuse
- ☐ Hepatitis

PAST SURGICAL HISTORY *Please list all previous surgeries.*

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

FAMILY HISTORY *Do you have a family history of any of the following? List which family member.*

- ☐ Heart Attack _____
- ☐ Breast Cancer _____
- ☐ Other Cancer _____
- ☐ Obesity _____
- ☐ Diabetes _____
- ☐ Alcoholism _____
- ☐ Psychiatric Disease _____
- ☐ High Blood Pressure _____

SOCIAL HISTORY

Marital Status ☐ *Married* ☐ *Single* ☐ *Divorced* ☐ *Separated* ☐ *Widowed*

Tobacco Use ☐ *Cigarettes* Packs/day _____ ☐ *Other Tobacco*

Alcohol ☐ *No* ☐ *Yes* How much _____

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

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

Medical History Form

ALLERGIES *Do you have any allergies to the following?*

- ☐ Medicines *List* _____
- ☐ Food *List* _____
- ☐ Environmental *List* _____

REVIEW OF SYSTEMS *Have you experienced any of the following?*

Constitutional
- ☐ Recent weight change
- ☐ Fatigue
- ☐ Headaches

Ear, Nose or Throat
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Bleeding Gums

Eyes
- ☐ Loss of vision
- ☐ Wear glasses/contacts
- ☐ Double/Blurred Vision

Breast
- ☐ Lumps
- ☐ Nipple discharge
- ☐ Cancer

Heart
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Swelling of legs

Skin
- ☐ Eczema
- ☐ Skin Cancers

Genitourinary
- ☐ Frequency at night
- ☐ Burning with urination

Respiratory
- ☐ Sleep Apnea
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough
- ☐ Blood in Sputum

GI
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Hiatal Hernia

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Cold Extremities

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

Signature ***Date***