H/K/B
GREENSBORO COSMETIC SURGERY

MEDICAL HISTORY

PATIENT INFORMATION

Name: _____ Date: _____

Gender: _____ Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Primary Doctor Name, Phone Number: _____

Pharmacy Name, Phone Number: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone Number: _____

Relationship to Patient: _____

PAST MEDICAL HISTORY

CONDITION/DISEASE	DURATION	ADDITIONAL DETAILS
○ None		
NEUROLOGICAL PROBLEMS		
○ Anxiety		
○ Depression		
○ Insomnia		
○ Migraine Headaches		
○ Seizures		
HEENT PROBLEMS		
○ Dry Eyes		
○ Glaucoma		
CARDIAC PROBLEMS		
○ High Blood Pressure		
○ High Cholesterol		
○ Heart Attack		
○ Pacemaker		
○ Other Heart Problems		
OTHER		
○ Pregnant/Breastfeeding		
○ Hx Cold Sores/Fever Blisters		

H/K/B
GREENSBORO COSMETIC SURGERY

PAST MEDICAL HISTORY CONT

CONDITION/DISEASE	YEAR BEGAN	ADDITIONAL DETAILS
PULMONARY PROBLEMS		
○ Mild Asthma		
○ Severe Asthma		
○ Sleep Apnea		
LIVER PROBLEMS		
○ Hepatitis (list type)		
STOMACH		
○ Constipation		
○ GERD (Reflux Disease)		
EXREMITY PROBLEMS		
○ Rheumatoid Arthritis		
BREAST PROBLEMS		
○ Fibrocystic Breast Disease		
○ Breast Cancer		Right or Left
ENDOCRINE PROBLEMS		
○ Diabetes		Type 1 or Type 2
○ Hyperthyroid		
○ Hypothyroid		
○ Multiple Sclerosis		
○ Lupus		
BLOOD PROBLEMS		
○ Anemia		
○ Easy Bleeding		
○ Factor V Liden		
○ Sickle Cell Trait		
○ Von Willebrands Disease		
○ Hx of DVT (leg blood clots)		
○ Hx of PE (lung blood clots)		
○ Stroke		
OTHER		
Hx of Accutane		

H/K/B
GREENSBORO COSMETIC SURGERY

PAST MEDICAL HISTORY CONT

CONDITION/DISEASE	YEAR BEGAN/DURATION	ADDITIONAL DETAILS
INFECTIOUS DISEASE PROBLEMS		
○ HIV		
ANESTHESIA PROBLEMS		
○ Difficult Extubating		
○ Difficult Intubation		
○ Malignant Hyperthermia		
OTHER		
○		

PAST SURGICAL PROCEDURES/HOSPITALIZATION/ SERIOUS INJURIES/FRACTURES

OPERATION/HOSPITALIZATION/INJURY	MONTH/YEAR
○ None	

FAMILY MEDICAL HISTORY

DISEASE	FAMILY MEMBER AFFLICTED

H/K/B
GREENSBORO COSMETIC SURGERY

ALLERGIES (Food, Drug, Seasonal, LATEX)

NAME	REACTION
○ None	

CURRENT MEDICATIONS AND SUPPLEMENTS (Including all prescription, over the counter, herbs, vitamins, supplements, birth control, include all legal/illegal)

NAME	DOES/STRENGTH	TO TREAT
○ None		

Signature: _____ Date: _____

Print Name: _____

Relationship to patient, if applicable: _____