Steven M. Zoellner, M.D.
PINEHURST PLASTIC SURGERY SPECIALISTS
BOARD CERTIFIED PLASTIC SURGEON

Patient History Form

Patient Name_____ Date of Birth_____

Reason for Consultation_____

Medical Physician_____Referring Physician_____

Height_____ & Weight_____ *If any weight loss or gain or loss please specify amount and over what time frame*_____

What is your current exercise regimen_____

Do you currently use tobacco products? Yes No If yes, how long have you used tobacco and how much per day? _____

Have you used tobacco products in the past? Yes No If yes, when did you last use tobacco products? _____

Please Circle Yes or No and the Condition that Applies To You

Yes No High Blood Pressure, Stroke, Heart Attack, Pacemaker, Irregular Heartbeat, Chest Pain, Congestive Heart Failure, Circulatory Problems, Mitral Valve Prolapse

Yes No Asthma, COPD, Emphysema, Shortness of Breath, Sleep Apnea

Yes No Have you had a Sleep Study and if so do use CPAP at night_____

Yes No Diabetes, Kidney Failure

Yes No Back or Neck Pain, Arthritis

Yes No Hepatitis, Jaundice, AIDS, HIV, Immunosuppressive Disorders

Yes No History of Blood Clots, Blood Disease, Bleeding Problems

Yes No Epilepsy, Sinus Problems, Headaches/Migraines

Yes No History of Cancer – If Yes, List Type & When_____

Yes No Anxiety, Depression, Chemical Dependency and/or under Psychiatric Care

Yes No Gastrointestinal Disorders, Ulcers, Chronic Diarrhea

Yes No Do you consume alcoholic beverages. If yes, how much & how often:_____

Yes No Do you use illicit drugs

Yes No Have you been instructed to take an antibiotic prior to dental work or surgical procedure.

Yes No Do you have any significant family history that we should be aware of:

_____

Allergies

(including both prescribed, over the counter, latex and betadine etc.)

_____ _____ _____ _____

Current Medications

(including both prescribed and over the counter, including herbal)

_____ _____ _____ _____

_____ _____ _____ _____

Past Surgical Procedures

_____ _____ _____ _____

Is there anything else we should know about your medical history:_____

Women Only

Last Menstrual Cycle_____ Number of Pregnancies_____

Number of children and ages_____ Planning Future Pregnancy? Yes No

If you are being seen for breast augmentation and/or breast lift please answer the following questions.

Current bra size_____ Desired bra size_____ When was your last mammogram_____

Yes No Did you breastfeed and if so, length of time_____

Yes No Have you ever had any breast problems (lumps, cancer, biopsies, abnormal mammogram) If yes please list type and when_____

Yes No Do you have any family history of breast cancer or breast problems. If yes please list type and relationship to family member_____

The above information is accurate and complete to the best of my knowledge

*Patient/Responsible Adult Signature*_____ Date_____

*Reviewed by Clinical Staff*_____ *Date*_____

*Reviewed by Physician*_____ *Date*_____