PINEHURST PLASTIC SURGERY SPECIALISTS, P.A.

ALLERGIES

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

_____ _____ _____ _____ _____

CURRENT MEDICATIONS

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

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Preferred Pharmacy and location_____

PAST SURGICAL PROCEDURES AND YEAR

_____ _____ _____ _____ _____

WOMEN ONLY-NEXT SET OF QUESTIONS

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, when did you stop?_____

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_____

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Patient History Form

Patient Name_____ **Date of Birth**_____

Reason for Consultation_____

Medical Physician_____**Referring Physician**_____

Height_____**Weight**_____**If any weight loss or gain please sprcify: weight loss**_____**lbs**

Weight gain_____**lbs In what time frame?**_____

What is your current exercise regimen?_____

Do you currently use tobacco products? Yes No If yes, how long have you been using 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, Circulatory Problems, Congestive Heart Failure, 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 you 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 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 procedures?Yes No

Do you have any significant family history that we should be aware of?_____