LENTZ PLASTIC SURGERY

MEDICAL HISTORY SHEET

Please Answer ALL Questions & Please Print

Patient's Name _____ Date: _____

REASON FOR TODAY'S VISIT _____

_____

PLEASE LIST ANY MEDICAL PROBLEMS THAT YOU NOW OR HAVE HAD IN THE PAST

	PROBLEM	WHEN PROBLEM BEGAN
EXAMPLE:	***HIGH BLOOD PRESSURE***	***JULY 1989***
1.		
2.		
3.		
4.		
5.		

IF YOU HAVE HAD SURGERY, PLEASE LIST YEAR AND TYPE OF SURGERY

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

WOMEN: ARE YOU PREGNANT? ____YES ___NO

FAMILY HISTORY: *If living, give present health information. If deceased, give age and cause of death.*

Father: _____ **Mother:** _____

Brothers & Sisters _____

LIST ALL CURRENT OR PRESENT MEDICATIONS, OVER THE COUNTER MEDICATIONS & SUPPLEMENTS

NAME	DOSE	HOW OFTEN TAKEN	NAME	DOSE	HOW OFTEN TAKEN

LIST ANY DRUGS YOU ARE ALLERGIC TO OR HAVE HAD ANY PROBLEMS WITH
ALSO LIST SYMPTOMS

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Please list your DAILY CONSUMPTION & LENGTH OF USE of each:

HAVE YOU EVER SMOKED: ___YES ___NO

If "Yes", How Many Packs Daily? _____ How Long?_____ Do you still smoke ___Yes ___No (Date that you quit _____/_____/_____)

DO YOU CONSUME ALCOHOL: ___YES ___NO

If "Yes", Indicate the Frequency: ___Daily ___Occasionally for _____ Years

ARE YOU PRESENTLY ON ANY SPECIAL DIET?

If "Yes", Please explain: _____

_____

PLEASE SEE OTHER SIDE

REVIEW OF SYSTEMS

PLEASE indicate by checking "YES" or "NO" if you presently have or have had a history of any of the following:

WEIGHT:_____ **HEIGHT:**_____

HEAD:

Headaches	YES	NO
Seizures	YES	NO
Dizziness	YES	NO
Fainting Spells	YES	NO
Injury	YES	NO

EYES:

Double Vision	YES	NO
Blind Spots	YES	NO
Dry Eye	YES	NO
Do you wear eyeglasses	YES	NO

Type of correction_____

_____

EARS:

Ringing	YES	NO
Hard of Hearing	YES	NO
Hearing Aid	YES	NO

NOSE:

Bleeding	YES	NO
Obstruction	YES	NO
Discharge	YES	NO

Do you have Restless Leg Syndrome?	YES	NO

MOUTH:

Fever Blisters	YES	NO
Bleeding Gums	YES	NO
Caps	YES	NO
Crowns	YES	NO
Dentures	YES	NO

THROAT:

Hoarseness	YES	NO
Soreness	YES	NO
Thyroid	YES	NO
Swallowing	YES	NO

LYMPH NODES:

Local or General Glandular Enlargement	YES	NO

RESPIRATORY:

TB	YES	NO
Short of Breath	YES	NO
Cough	YES	NO
Wheezing	YES	NO
Asthma	YES	NO

CARDIOVASCULAR:

Pacemaker	YES	NO
Hypertension *(High Blood Pressure)*	YES	NO
Rheumatic Fever	YES	NO
Edema *(swelling arms/legs)*	YES	NO
Heart Murmur	YES	NO
Pericardial Pain *(chest pain)*	YES	NO
Hypotension *(Low Blood Pressure)*	YES	NO
Phlebitis *(Inflammation of Veins)*	YES	NO
Heart Disease	YES	NO

GASTROINTESTINAL:

Gallbladder	YES	NO
Nausea	YES	NO
Diarrhea	YES	NO
Blood in Stool	YES	NO
Ulcer	YES	NO
Vomiting	YES	NO
Constipation	YES	NO

GENITOURINARY:

Urinary Tract	YES	NO
Venereal Disease	YES	NO
Kidney Disease	YES	NO

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN:_____

_____

_____

_____

_____

_____

_____

Are you currently being treated for any Emotional or Psychological Problems? YES NO

Have you been treated for any Emotional or Psychological Problems in the past? YES NO

If "Yes", please explain_____

_____

Have you ever had any Bleeding Problems? YES NO

Have you ever had any Bleeding Problems with a Surgical or Dental Procedure? YES NO

Have you ever had any Blood Transfusion or Blood Products? YES NO

If "Yes", please explain_____

_____

_____

Have you ever had General Anesthesia? YES NO If "Yes", Did you have a reaction to the Anesthesia?_____

_____

Have you ever been Diagnosed with an Infectious Disease such as HIV, Hepatitis, Syphilis, Tuberculosis? YES NO

If "Yes", please explain: _____

_____