North Dallas Plastic Surgery Associates

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MEDICAL HISTORY

Name _____ Date _____

Specific reason for consultation: _____

Age _____ Height _____ Weight _____ Marital Status S M D W

Allergies List ANY reactions you have had to medications and describe the symptoms.

_____

Medications List ALL prescription, over-the-counter & herbal medications you have taken recently with dosages.

_____

_____

_____

Past Medical History List ANY medical conditions for which you have been treated.

_____

_____

_____

Past Surgical History List ALL previous surgery; include complications or abnormal reaction to anesthetics

_____

_____

Social History

Occupation _____

Exercise Habits _____

Cigarette Smoking Yes No _____ packs per day

Alcohol None Occasional Moderate Excessive

Drug Use _____

Family History CIRCLE any of the following that effect first degree relatives

Anesthetic Problems High Blood Pressure Heart Disease Breast Cancer Diabetes

Bleeding Disorders Mental Illness Hereditary Disease Other _____

MD Initial _____