CENTER FOR
Cosmetic &
Plastic Surgery

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PLEASE PRINT

HISTORY AND PHYSICAL

Today's Date ____________________

Name ______________________________________ Date of Birth __________ Age ________

Anticipated type of procedure: ______________________________________

All of the following questions are to be completed by the patient by checking YES ☐ or NO ☐. If you check "Yes", please explain in the space provided.

	YES	NO
Do you have at present:		
Chronic cough	☐	☐
Chronic bronchitis	☐	☐
Asthma *(as an adult)*	☐	☐
Emphysema	☐	☐
Do you smoke?	☐	☐
How much? ________________		
If you quit smoking, when was your last cigarette? ____________		
Do you drink alcohol?	☐	☐
How much? ________________		
Have you had the following:		
Heart Murmur	☐	☐
Mitral valve prolapse	☐	☐
If so, have you been told to take antibiotics prior to dental work?	☐	☐
High blood pressure	☐	☐
Skipped heart beats	☐	☐
Chest pains	☐	☐
Hardening of the arteries	☐	☐
Heart failure or attack	☐	☐
Have you ever seen a cardiologist for any of the above problems?	☐	☐
If so, who? ________________		
What city? ________________		
Do you have sickle cell disease	☐	☐
Other disease of blood cells	☐	☐
Abnormal blood clotting	☐	☐
Have you been diagnosed with:		
Jaundice	☐	☐
Hepatitis	☐	☐
HIV	☐	☐
Kidney failure	☐	☐
Autoimmune disorder	☐	☐

	YES	NO
Do you have any of the following:		
Brain disease	☐	☐
Spinal cord disease	☐	☐
Nerve disease *(MS, polio, etc.)*	☐	☐
Epilepsy	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Thyroid disorder	☐	☐
Glaucoma	☐	☐
Do you wear contact lens?	☐	☐
Do you have problems with stomach, bowel or gallbladder?	☐	☐
If so, what: ____________________		
Do you have:		
Bridges, crowns or dentures	☐	☐
Loose teeth	☐	☐
Problem opening mouth wide	☐	☐
Problem turning head	☐	☐
Do any diseases run in your family?	☐	☐
What?____________________		
Pertains to females:		
Are you currently pregnant, or could you be pregnant?	☐	☐
It is your responsibility to inform this office if pregnancy is even a possibility. ***Surgery would not be recommended if you are.***		
Have you breast fed in the past three months?	☐	☐
Number of pregnancies ________		
Number of children ________		

PLEASE If you checked "Yes" to any of the above questions, explain: ______________________________

____

____

PLEASE TURN OVER, THERE IS MORE ON THE BACK

What is your height? __________ Weight? __________ Do you bruise easily? __________ Faint easily? ________

Have you had a complete medical physical in the past 12 months? ______________________________

Have you had an electrocardiogram within the past 12 months? ______________________________

Who is your medical doctor? ____________________ City ________________ Phone __________

List ALL surgeries you have EVER had. If none, please write "NONE".

Date	Operation	Surgeon	Complications *(if any)*

Anesthetic History	**YES**	**NO**
Any blood relative with serious allergy to anesthesia drug?	☐	☐
Any problems with anesthesia?	☐	☐

If you checked "Yes" to any of the above questions,

please explain: ______________________________

____

____

____

Allergies *(if none, please write "NONE")*

Drug name Reaction

____

____

____

____

Please list ALL medications you are currently taking.

Name and dosage of medication:	Reason for taking this medication:

Please sign: ______________________________ Date: ____________________

(Patient Signature)