Bayview Plastic Surgery

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Patient Name: _____ Birth date: _____

Please answer all of the questions as accurately as possible. If you do not understand the question, please ask for assistance.

Primary Care Doctor: _____

Smoking (type and amount per day) _____ Alcohol (type and amount per week) _____

If former smoker, date you quit: _____ Weight: _____ Height: _____

Drug allergies: _____

Are you allergic to any topical preparations? ❑ Tape ❑ Betadine ❑ Latex ❑ Other_____

List previous surgeries or major illnesses and dates (including any plastic surgery): _____

_____

List any medications you are taking, including non-prescription drugs, vitamins and herbals: _____

_____

Family History: Has any blood relative ever had the following:

Breast cancer……	no	yes	High blood pressure…..	no	yes	Kidney disease……	no	yes
Melanoma……..	no	yes	Heart disease……..	no	yes	Depression……..	no	yes
Stroke……	no	yes	Diabetes……...	no	yes	Blood clots, deep venous thrombosis or pulmonary embolus (PE)……..	no	yes

Past Medical History: Have you ever had the following:

Heart disease……...	no	yes	Cancer……	no	yes	Stomach Ulcer……	no	yes
Arthritis……..	no	yes	Glaucoma……	no	yes	Kidney disease……	no	yes
Anemia……..	no	yes	Asthma……	no	yes	Thyroid disease……..	no	yes
Tuberculosis…….	no	yes	AIDS or HIV+……..	no	yes	Bleeding tendency……..	no	yes
Diabetes……	no	yes	Stroke……..	no	yes	Mitral Valve Prolapse….	no	yes
Blood clots, deep venous thrombosis or pulmonary embolus (PE)……...	no	yes	Hepatitis…… (What type? _____)	no	yes	High Blood Pressure…..	no	yes

Review of Systems: Do you have now or have you had within the past year:

Weight Change……	no	yes	Swollen feet/ankles……	no	yes	Seizures……	no	yes
Dry eyes……	no	yes	Skin rash……..	no	yes	Joint or muscle pain……	no	yes
Chronic cough……	no	yes	Chronic diarrhea…….	no	yes	Swollen lymph nodes….	no	yes
Chest pain……	no	yes	Jaundice……..	no	yes	Easy bleeding……..	no	yes
Rapid heart beat…….	no	yes	Depression……..	no	yes	Easy bruising……..	no	yes

Women only:

Age period began: _____ Number of pregnancies:_____

Date of last mammogram: _____ Did you breast feed? no yes

Do you do regular breast self-examinations? _____ Breast lump or discharge? no yes

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____ _____

Signature of patient Date