

Today's date: _____

FILL OUT COMPLETELY. WE MUST HAVE YOUR COMPLETE MEDICAL HISTORY AND MEDICATION LIST IN ORDER TO SCHEDULE YOUR SURGERY AND OBTAIN ANY NECESSARY CLEARANCES PRIOR TO SURGERY. IF YOU DO NOT HAVE YOUR COMPLETE MEDICAL HISTORY AND MEDICATION LIST WITH YOU, PLEASE INFORM OUR PROVIDER DURING YOUR APPOINTMENT.

Patient Name _____ DOB _____ Height _____ Weight _____ BMI _____

CHECK YES OR NO TO ALL MEDICAL CONDITIONS BELOW

No	Yes		No	Yes	
		Asthma			Hypothyroidism
		Allergies			Diabetes
		COPD			Obesity
		Sleep apnea, do you use CPAP?			Osteoarthritis
		Hypertension			Rheumatoid arthritis
		Coronary artery disease			Gout
		Congestive heart failure			Fibromyalgia
		History of heart attack, when			Anxiety
		Pacemaker/defibrillator			Depression
		Atrial fibrillation			PTSD
		History of pulmonary embolism, when			Attempted suicide
		History of DVT, when			Anorexia/bulimia
		Stroke, when			Dementia
		Edema (swelling)			Delayed wound healing
		Varicose veins			Keloids
		Anemia			Cellulitis
		Hemophilia			Sepsis
		Hypercholesterolemia			Dementia
		Blood transfusion			History of unexplained stillborn infant
		Hepatitis C			3 or more miscarriages
		HIV/AIDS			Melanoma
		Herpes			Basal or squamous cell carcinoma
		Tuberculosis			Cancer
		MRSA			Organ transplant
		Family history of pulmonary embolism or DVT			Personal or family history of malignant hyperthermia

Please list any other Medical Conditions you have not listed above:

Do you see a Cardiologist? If yes, who _____
Women ONLY: When was your last Mammogram _____ Was it normal No Yes

Family History: DO YOU HAVE ANY FAMILY HISTORY OF MEDICAL PROBLEMS? List All

Social History:

Do you Drink Alcohol No Yes, drinks per week _____
Do you Smoke Cigarettes Never Former smoker, quit when _____ Yes, cigarettes per day _____
Do you use any Nicotine Substance (chew, dip, gum, patches) No Yes _____
Do you smoke or use any form of Marijuana No Yes, type and frequency _____
Do you use any Illicit Drugs No Yes, type and frequency _____
Have you ever been treated for Substance Abuse No Yes, when and type of substance _____
Occupation: _____

Review of Systems

CIRCLE ANY/ALL THAT APPLY TO YOU TODAY

General/Constitutional: Changes in appetite, Chills, Fever, Headaches, Weight gain, Weight loss.

Bad reaction to general anesthesia? No / Yes

Head/Eyes/Ears/Nose/Throat: Blurry vision, Eye pain, Tearing excess, Decreased hearing, Snoring, Sore Throat.

Endocrine: Cold intolerance, Excessive thirst, Heat intolerance.

Respiratory: Cough, Shortness of breath, Wheezing.

Breast: Breast lump, Breast pain, Breast swelling, Nipple discharge, Rashes, Red skin.

Cardiovascular: Chest pain, Dizziness, Palpitations.

Gastrointestinal: Abdominal pain, Constipation, Diarrhea, Nausea, Vomiting.

Genitourinary: Blood in urine, Difficulty urinating.

Musculoskeletal: Muscle aches, Joint pain, Swollen joints.

Peripheral Vascular: Bleeding disorder, Blood clots, Pain/cramping in legs after walking

Skin/Integumentary: Scarring problems, Rash.



Ohio Plastic and Reconstructive Surgery LLC
112 Morey Dr. Marysville, OH 43040

Signature: _____

Date: _____

(Patient signature; parent or guardian signature if patient is a minor)

Thank You for Trusting
Ohio Plastic and Reconstructive Surgery!