MEDICAL HISTORY FORM

Name: _____ Age: _____

Male / Female Height_____ Weight_____

Your **Referring** Doctors Name & Telephone_____

Your **Primary** Doctors Name & Telephone_____

Your **Cardiologist** Name & Telephone_____

Your **Dermatologist** Name & Telephone_____

Your **Pharmacy** Name & Telephone_____

Are you allergic to **latex**? □ Yes □ No

Are you allergic to any **medications**? □ Yes □ No -- Are you allergic to any **foods**? □ Yes □ No

If yes, please list: _____
_____

Do you have or have you had any of the following ailments (circle yes or no and give date of occurrence)

Bleeding Problems	No Yes _____	Arthritis	No Yes _____
Digestive Problems	No Yes _____	Asthma	No Yes _____
Dermatologic Problems	No Yes _____	Cancer	No Yes _____
Ear, Nose, Throat Problems	No Yes _____	Diabetes	No Yes _____
Genital (GYN, Prostate, etc)	No Yes _____	Heart Disease	No Yes _____
Musculo-skeletal Disorders	No Yes _____	Hepatitis	No Yes _____
Neurologic Disorders	No Yes _____	Heart Attack	No Yes_____
Psychiatric Disorders	No Yes _____	Stroke	No Yes _____
Seizures	No Yes _____	Lyme Disease	No Yes _____
Respiratory Problems	No Yes _____	Chest Pain	No Yes _____
High Blood Pressure	No Yes _____	Kidney Problems	No Yes _____
Eye Problems	No Yes _____	Anemia	No Yes _____
Thyroid Disease	No Yes _____	HIV	No Yes _____
Bruise Easily	No Yes _____	Sleep Apnea	No Yes _____
Cold Sores/Herpes	No Yes _____		

Have you ever received a **Flu vaccine**? □ No □ Yes, when?_____
Have you ever received a **Pneumonia vaccine** ? □ No □ Yes, when?_____

Have you been discharged from an **in-patient facility** in the last month? □ No □ Yes

Do you take **prophylactic antibiotics**? □ No □ Yes
Other:_____

Past Surgeries (state year & type of operation)

_____
_____
_____
_____

SOCIAL HISTORY

Do you smoke? Yes No Packs per day? _____

Have you smoked in the past? Yes No Packs per day? _____ Quit date: _____

Do currently consume alcohol? Yes No Amount per day? _____

Do you have, or have you had an alcohol abuse problem? Yes No Quit date: _____

Do you have a drug abuse problem now? Yes No

Have you had a drug abuse problem in the past? Yes No

FEMALE PATIENTS

Last menstrual period: _____

Number of pregnancies: _____ Number of live births:_____

Last PAP Smear: _____ Date of last mammogram: _____

Breast disorder (describe): _____

FAMILY HISTORY

Mother: Alive or Deceased (if deceased, cause of death _____)

Age _____ Health Problems_____ Diabetes _____ Insulin? Yes No

Father: Alive or Deceased (if deceased, cause of death_____)

Age _____ Health Problems_____ Diabetes _____ Insulin? Yes No

Siblings with same condition _____

I hereby authorize Plastic Surgeons of the Hudson Valley to disclose, when requested, any and all information with respect to the above named patient, for any illness or injury, medical history consultation, prescriptions or treatment and copies of all medical records. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A copy of this authorization shall be considered effective and valid as the original.

I verify that the above information is true and accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Print Name _____ Relationship if Guardian _____