PRINCETON PLASTIC SURGERY ASSOCIATES
Medical History Questionnaire

PATIENT NAME:_____DATE OF BIRTH:_____AGE:_____

Reason for visit:_____

MEDICAL HISTORY: Please check the following:

Height_____Weight_____

High Blood Pressure	yes_____no_____
Bleeding Disorder	yes_____no_____
Anemia	yes_____no_____
Liver Disease	yes_____no_____
Heart Disease	yes_____no_____
Thyroid Disease	yes_____no_____
Lung Disease	yes_____no_____
Skin Disease	yes_____no_____
Tuberculosis	yes_____no_____
Hepatitis	yes_____no_____
HIV	yes_____no_____
Cancer	yes_____no_____
Diabetes	yes_____no_____
Anxiety	yes_____no_____
Depression	yes_____no_____

MEDICATIONS CURRENTLY TAKEN:

1._____what is it for_____

2._____what is it for_____

3._____what is it for_____

4._____what is it for_____

ALLERGIES and/or SENSITIVITIES:

Penicillin yes____ no_____if yes, what happens_____

Sulfa yes____ no_____if yes, what happens_____

Other antibiotics yes____ no_____if yes, what happens_____

Xylocaine yes____ no_____if yes, what happens_____

Epinephrine yes____ no_____if yes, what happens_____

Percocet yes____ no_____if yes, what happens_____

Codeine yes____ no_____if yes, what happens_____

Surgical tape yes____ no_____if yes, what happens_____

Latex yes____ no_____if yes, what happens_____

Other allergies _____

SURGICAL HISTORY:

Please supply information about any prior surgeries:

1_____ Date_____

2_____ Date_____

3_____ Date_____

4_____ Date_____

5_____ Date_____

List any complications or problems you experienced during or following the above procedures:

PRIMARY PHYSICIAN:

Name:_____

Phone Number_____

Have you had a physical in the past 3 months? Y/N Date:_____

Have you had a physical in the past year? Y/N Date:_____

REFERRING PHYSICIAN:

Name:_____

Phone Number_____

FAMILY MEDICAL HISTORY:

List any information about disease or conditions such as cancer, heart issues, stroke, etc.

Father_____

Mother_____

Siblings _____

Grandparents_____

SOCIAL HISTORY:

Smoking: Currently / Past / Never

Frequency:_____

Alcohol: Currently / Past / Never

Drinks per day/week:_____

Recreational Drug Use: Currently / Past / Never

Type/frequency:_____

Signature of Patient or Guardian Date