PREOPERATIVE HISTORY AND PHYSICAL INFORMATION

Patient's Name ____Date__________________

Home
Address____

Phone Number____

Present Problems

Please describe your specific problem(s).____

____

Have you consulted the doctors, including plastic surgeons, about this problem(s)? NO YES

If yes, please list their names.____

____

Past Medical History

General health: excellent good fair poor

If fair or poor, please explain.____

____

Height_______________Weight______________

Weight loss/gain in past year___________________(lbs. gained/lost)

How long ago was your most recent physical examination?_______________________________________

Did it include an electrocardiogram?______________chest x-ray?_____________________

Name and address of physician who performed the physical______________________________________

____

Please list any serious illnesses.____

____

____

Date of Last Menstrual Period______________________

PREVIOUS SURGERIES:

Operation Year Hospital City

____

____

____

____

Surgeon(s)

____

____

____

____

Were they done under a local/general anesthesia?____

Were there any significant complications?____

If yes, please explain.____

____

Please list any previous injuries.____

____

Family History

Please give age and state of health for each.

Mother:____

Father:____

Children:____

Brothers:____

Sisters:____

Medications/drugs
What is your daily consumption of:

Coffee/tea________________________________

Tobacco__________________________________

Alcohol___________________________________
Other intoxicating of mind-altering
drugs____

____

Please list **all** medications that you are now taking and dosages including diet pills and herbal supplements:

____

____

Preoperative information (You may not know the answers to some of these questions. If not, please blank and ask the nurse who does your preop.)

Are you allergic to any medications? yes no

Please identify____

Have you ever reacted badly to being put to sleep for surgery? yes no
Has any member of your family reacted badly to being put to sleep for surgery? yes no
Have you required unusually large doses of local anesthetic for medical or dental procedures? yes no
Have you ever had a bad reaction to local anesthetic (novocaine)? yes no
Are you allergic to adhesive tape? yes no
Are you allergic to suture material? yes no
Do you have high blood pressure? yes no
Do you bleed unusually or easily from cuts, etc...? yes no
Do you bruise very easily? yes no
Do you form large scars of keloids? yes
no
Do you have frequent infections or boils? yes no
Do you have any skin disease, hives, or rashes? yes no
Have you had steroid medications, cortisone, or ACTH? yes no
Do you have shortness of breath when walking? yes no
Does your religion prohibit blood transfusions? yes no
Do you have, or have you ever had any significant emotional problems? yes no
Have you ever had psychiatric care? yes no
Have you ever been advised to see a psychiatrist? yes no

Signature:____

Relationship to patient:____
(self, parent, spouse)