Fearrington Plastic Surgery / Patient History Sheet

Name: _____ Age: _____ Date: _____

Date of Birth: _____ Primary Care Physician: _____

Height: _____ Weight: _____ Sex: ❑ Male ❑ Female

Breast Implants Only Bra Size: _____ Would Like to Be: _____

Date of Last Physical: _____ Date of Last Mammogram: _____

Please answer each question by placing a "Y" (yes) or "N" (no) in the space provided. If you do not understand a question, please place a "?" instead.

_____ Recent or present illness

_____ Asthma

_____ Hay Fever

_____ Pneumonia, Tuberculosis

_____ Pulmonary Embolus

_____ Emphysema

_____ Shortness of breath

_____ Smoking If yes, how much per day? _____

Date of last chest x-ray: _____

_____ Rheumatic fever

_____ Heart attacks

_____ High blood pressure

_____ Low blood pressure

Date of last EKG: _____

_____ Convulsions, Epilepsy

_____ Stroke or dizziness

_____ Diabetes

_____ Anemia

_____ Mental or emotional illness

_____ Bleeding disorders

_____ HIV or hepatitis

_____ Pregnant

Other illnesses not mentioned: _____

_____ Do you drink alcohol? If yes, how much: _____

_____ Are you allergic to medications? If yes, please list: _____

_____

_____ Have you taken any medications recently? Please list all medications including over the counter (and amount you take per day): _____

_____

_____ Cancer chemotherapy

_____ Blood thinners, anticoagulants, aspirin, or ibuprofen

_____ Pain pills and/or shots

_____ Steriods, Cortisol, Medrol, or Predinisone

_____ Surgeries If yes, list all and if general anesthesia, local, or IV sedation: _____

_____

_____

How did you hear about us? _____

I have answered the questions concerning my health to the best of my knowledge.

Patient signature: _____