



Division of Plastic Surgery
Patient Medical Data Sheet

Name: _____

Date of Birth: _____ Height: _____ Weight: _____ Are you pregnant? No Yes

Reason(s) for today's visit _____

Is this problem due to an accident? No Yes Date: _____ Auto Work Other _____

Medical History: _____

Past Surgeries: _____

Current medications with dosages: _____

Allergies: _____

Family history: _____

Do you smoke? No Yes How much? _____ Do you drink alcohol? No Yes How much? _____

Do you currently use any unprescribed drugs (ex: marijuana, cocaine) No Yes

Have you ever felt unsafe or been afraid of anyone? No Yes

Do you have difficulties with any of the following (**Circle**) *Eating, Dressing, Hygiene, Walking, Toileting, Getting in or out of bed*

Do you experience pain as part of your daily life? No Yes - If yes, on a scale from 1 - 10, **please rate your pain:**
For example: 0 = no pain, 1 - 2 = slight pain, 6 - 7 = moderate pain, 10 = worst pain possible: (_____)

How do you treat this pain? _____

Have you lost or gained more than 10 pounds in the last three months without trying? No Yes

Do you have a health care proxy? No Yes

History of falls? No Yes If yes, circumstance initiating fall: _____

Review of Systems: Do you have any problems with? (Please check yes or no for each condition below)

Anxiety/Depression	<input type="checkbox"/> Y <input type="checkbox"/> N	Eye/Vision	<input type="checkbox"/> Y <input type="checkbox"/> N	Neurological Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N
Back or Joints	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart	<input type="checkbox"/> Y <input type="checkbox"/> N	Skin Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding/Clotting	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Stomach/Abdominal	<input type="checkbox"/> Y <input type="checkbox"/> N
Breathing	<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer/Tumor	<input type="checkbox"/> Y <input type="checkbox"/> N	HIV/ARC/AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N	Weight Changes	<input type="checkbox"/> Y <input type="checkbox"/> N
Eating /Appetite	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Other	_____

Additional information: _____

Date _____ Time _____ Patient Signature _____

Date _____ Time _____ Physician Signature _____ MD

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