Plastic Surgery Patient Health History

Name: ______________________________ Preferred Name: ____________ Pronouns: __________

Address: ______________________________ City: ________________ State: ______ Zip: ______

Primary Phone: ____________ Secondary Phone: ____________ Email: ____________________

Emergency Contact: __________________ Contact's Phone: ______________ Relationship: ________

Primary Care Physician: ____________________ PCP Location: Polyclinic / Swedish / Kaiser / Other:________

How did you hear about us? (List Referring Physician, if applicable): ______________________________

Reason for coming in today: ____

Date of Birth: __________ Age: ______ Height: ______ Weight: ________

Medical History: (Please check box below if you have any of the following symptoms or history of problems/diseases)

Anesthesia: **□ Difficult Airway □ ANY Problems with Anesthesia** ______________________________

Head/Neck: □ Hearing Problems □ Eye Problems □ Nose/Sinus problems □ Dental (Dentures) □ Other: ____________

Heart: □ h/o Heart Attack □ Chest Pain □ Irregular Heart Beat □ High Blood Pressure □ Other: ____________

Lungs: □ Asthma □ COPD □ Sleep Apnea □ Shortness of Breath □ Chronic Cough □ Other: ____________

Breast: □ Cancer (date diagnosed ______) Treatment/date: ________________ □ Other: ____________

GI: □ Reflux □ Ulcers □ Abdominal Pain □ Cancer (type) ________________ □ Other: ____________

Nervous System: □ Seizures □ Memory Loss □ Multiple Sclerosis □ Fibromyalgia □ Other: ____________

Endocrine: □ Diabetes □ Thyroid disorder □ Other: ______________________________

Hepato/Urinary: □ Kidney Problems □ Infections □ Hepatitis □ Other: ______________________

Psychological: □ Depression □ Bipolar Disorder □Anxiety □ Other: ______________________

Skin: □ Rashes □ Eczema □ Psoriasis □ Skin Cancer (type: ________) □ Botox □ Fillers □ Other: ____________

Musculoskeletal: □ Arthritis □ Joint Problems □ Muscle Problems □ Other: ______________________

Hematology/Oncology: □ Blood Clotting Disorder □ Family History of Blood Clotting Disorder □ Factor V Leiden
□ Phlebitis □ Anemia □ HIV □ Lymphoma □ Leukemia □ Other: ______________________

Other Medical History: ____

ALLERGIES: ____

MEDICATIONS: ____

□ Oral Contraceptives □ Hormone Therapy □ NSAIDS □ Aspirin □ Plavix □ Coumadin □ Pradaxa □ Other Blood Thinners

Surgical History: (Check all that apply and explain w/ date)

□ Heart: ____________________ □ Lung: ____________________

□ Breast: ____________________ □ Gynecological: ____________________

□ Abdomen: ____________________ □ Orthopedic (bones): ____________________

□ Eyes: ____________________ □ Ear/Nose/Throat: ____________________

□ Cosmetic / Other: ____

Social History: Occupation/Employer: ____________________ Lives with: ____________

□ Current Nicotine or Marijuana Use □ Previously Used/Date of Use: ________

□ Alcohol (______ drinks per week) □ Other Drugs Using/Used: ____________ [Patient Label]

______________________________ __________

Signature of Patient or Legal Guardian Date

For staff: □ ICON □ CCON □ Verified in Epic