NORTHEAST PLASTIC SURGERY
CENTER

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Patient History

Name _____ Date _____

DOB _____ Age _____

Referring Physician _____ Primary Physician _____

Reason for Visit _____

Medical History (circle all that apply)

Eyes:	Field of vision issues	Glaucoma	Cataracts	Dry eyes
Breast:	Benign breast disease			
Breast Cancer:	Right	Left	*when?*	_____
	Chemotherapy	Radiation		
Cardiovascular:	High blood pressure	Heart attack:	*when?*	_____
	CHF	Coronary Artery Disease	Arrhythmia	High Cholesterol
	Peripheral Vascular Disease			
Lungs:	COPD/emphysema	Asthma		
Endocrine:	Diabetes	Thyroid:	*Low or High*	
Kidney:	Kidney disease	Dialysis		
Neurologic:	Stroke	Lyme Disease		
Blood:	DVT	Bleeding issues		
Skin:	Skin cancer:	*what type and where?*		_____
Psychiatric:	Depression	Anxiety		
Infectious:	HIV	Hepatitis:	*A / B / C*	

Other (explain): _____

Medical History (continued)

Are you or could you be pregnant?	Yes	No
Are your menstrual period regular?	Yes	No
Do you have a history of Herpes I or II in the area to be treated?	Yes	No
Do you have a history of keloid scarring (overly thickened scar)?	Yes	No
Have you taken Accutane or anticoagulants in the last 12 months?	Yes	No

Do you have permanent makeup, implants, or tattoos? *If yes, list locations* _____

_____

What is your current skin care regimen? _____

_____

Surgical History (non-cosmetic) (with approximate dates)

Eyes: _____

Breast: _____

Lymph node surgery: _____

Cardiovascular (includes pacemaker and IVC filter: _____

Lungs: _____

Abdominal surgeries: _____

GYN (including C-section, tubal ligation): _____

Neurosurgery: _____

Thyroid/kidney: _____

Skin (i.e. cancer removal): _____

Other: _____

Cosmetic Procedures (circle all that apply, with approximate dates)

Blepharoplasty (eyelid lift)	Facelift	Rhinoplasty (nasal surgery)
Breast reduction	Breast augmentation	Breast lift
Abdominoplasty		

Liposuction: where? _____

Laser Therapy/IPL/etc: *where?* _____

Other: _____

Allergies (medication/food/latex/other) and associated **reaction**

Medications (with dosages) including Over-the-Counter medications, supplements, topicals, injectable, and intravenous

Social History

Do you smoke cigarettes/cigars/pipes (circle one)? Yes No

If Yes, how much and how often?

Do you use other nicotine products, such as nicotine gum or nicotine patch? Yes No

Do you drink alcohol? Yes No

If Yes, how much and how often?

Do you use any illicit drugs (circle one; medical confidentiality applies)? Yes No

If Yes, what drug and how often?

Occupation and duties

Family Illnesses (i.e. diabetes, high blood pressure, breast cancer, genetic testing, etc.)

Approximate Height Approximate Weight

Significant weight: *Loss?* *Gain?* How much/over what time?

For all breast surgery patients, what is your bra size?

For all surgical patients, are you agreeable to receiving blood products if necessary? Yes No

Preferred pharmacy

Our practice may release my protected health information to:

Name Your initials

Name Your initials

Name Your initials