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* _____

Surgical History (all surgeries, including cosmetic) (with approximate dates)

Eyes (*including* eyelid lift): _____

Breast (*including* biopsy, lumpectomy, mastectomy, reduction, augmentation, lift): _____

Lymph node surgery: _____

Cardiovascular (includes pacemaker and IVC filter): _____

Lungs: _____

Abdominal surgeries (*including* abdominoplasty): _____

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

Neurosurgery: _____

Thyroid/kidney: _____

Skin (i.e. cancer removal): _____

Other: _____

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

_____

Allergies to tissue glue/chlorhexadine/Betadine/adhesives? Type? _____

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

_____ _____

_____ _____

_____ _____

Social History

Do you smoke cigarettes/cigars/pipes/vape (circle all that apply)? 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.)

_____

Support System

Please note that it is imperative that you have adequate support not only to and from your operative visit (if applicable), but also support throughout your recovery process.

Please list who lives at home with you:

_____

Do you have a caretaker that you can readily rely on to assist with activities of daily living, medication management, wound dressings, placing and removing your surgical garment(s), etc.? | Yes | No |

If you answered "No," specify areas where you lack support:

_____

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 _____