

Washington Plastic Surgery Group Health History Form

Name: _____	
Hgt: _____	Wgt: _____

PLEASE LIST ALL MEDICATIONS TAKEN.

<u>Medication</u>	<u>Dosage</u>	<u>How Often</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE CHECK ALL THAT APPLY:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Recent cold | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Anemia | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Copd |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Dentures | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Sexually/Blood Transmitted Disease | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> | <input type="checkbox"/> Fainting/Dizziness <input type="checkbox"/> |
| | | <input type="checkbox"/> Prolonged Breathing <input type="checkbox"/> | |

Drug Allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list: _____	Allergy to Latex? <input type="checkbox"/> Yes <input type="checkbox"/> No Reaction? <input type="checkbox"/> Rash <input type="checkbox"/> Hives
Do you Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No Packs Per Day? _____ No. of years smoking? _____ Shortness of breath? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you Drink Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No How Much? _____ How Often? _____

Have you or any member of your immediate family had an unusual reaction to Anesthesia? _____

If so – please describe: _____

Have you had surgery before? Yes No

Please list: _____

Patient Signature: _____ Date: _____