Carolina Plastic Surgery, P.A.

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HISTORY & PHYSICAL FORM

Today's Date: _____ **Referred By: _____**

Patient Name: _____ Age: _____

Reason for today's visit /brief history:

_____

_____

MEDICAL HISTORY:

1. **Previous or current medical problems:**
   _____
   _____
   _____
   _____
   _____

2. **Do you have or have you ever had any form of hepatitis or HIV? Yes or No**

3. **Allergies to Medications: _____**

   Allergies to Food (s): _____

4. **Are you allergic to iodine (shellfish, IVP dye for kidney x-rays /dye for arteriogram) Yes NO**

   A. Are you allergic to latex (natural rubber, bananas, and kiwi)? Yes No

5. **Medications you take regularly or occasionally:**

   _____ _____
   _____ _____
   _____ _____
   _____ _____

6. **Do you ever take diuretic (water pills) Yes No**

7. **Do you bruise easily? Yes No**

A. **Have you ever had problems with bleeding during surgery? Yes or No**

B. **Do you ever take aspirin products, such as Goody or BC Powder, Motrin, Advil Nuprin, Ibuprofen, Naprosyn, Anaprox, Other: _____ or any on the list of products and medications included in your packet?**

If yes, please list: _____
_____

C. **Do you take vitamins and/or herbs (Fever Few, Green Tea, Ginko Biloba, W*ill*ow *Bark,* Vitamin A, Vitamin E etc.? If yes, please list:**
_____
_____

8. **Past surgical procedure and or hospitalizations (include dates):**
_____
_____
_____
_____

Have you had any anesthesia –related problems during or after surgery? Yes or No

9. **Have you or a family member ever had a high fever during or immediately after surgery? Yes or No If yes, explain:_____**

10. **Does anyone in your family have a history of malignant hyperthermia? Yes No Is yes explain: _____**

11. **Do you have a high temperature/fever after exercising? Yes No**

12. **<u>FAMILY HISTORY:</u>**

Has anyone in your family had any of the following?

Heart Disease? Yes No Who? _____

High Blood Pressure? Yes No Who? _____

Cancer? Yes No Who? _____

Addiction? Yes No Who? _____

Diabetes? Yes No Who? _____

13. **<u>EENT:</u>**

Do you have problems with your eyes, ears, nose, or throat? YES NO

If yes explain: _____

14. **Do you Smoke or use any form of tobacco? Yes No (Vape, Nicorette gum, patches or pills) YES or NO If so which form? _____ How much: _____ (Explain)**

Does your spouse, significant other or anyone in your household smoke? Yes or No

Cardiovascular:

15. **Do you have problems with your heart? YES NO (chest pain, heart attack, high blood pressure, heart murmur) If yes, explain: _____**

Date of last physical examination: _____

Date last Electrocardiogram performed? _____

Do you ever get short of breath? Yes No

Do your ankles swell? Yes No

16. **GI:**

Do you have problems with ulcers?	**Yes**	**No**
Have you ever vomited blood?	**Yes**	**No**
Have you ever passed blood in your stool?	**Yes**	**No**
Do you have diabetes?	**Yes**	**No**
Have you had gallbladder trouble?	**Yes**	**No**
Have you ever had yellow jaundice?	**Yes**	**No**

17. **GU:**

Have you ever had any trouble with kidney stones?	**Yes**	**No**
Have you ever had any trouble with kidney infections?	**Yes**	**No**
Do you have trouble with bladder infections?	**Yes**	**No**
Men: do you have prostate trouble?	**Yes**	**No**
Women: Are your periods regular?	**Yes**	**No**
Any excessive bleeding?	**Yes**	**No**
Are you pregnant?	**Yes**	**No**

18. **Neuromuscular:**

Do you have seizures?	**Yes**	**No**
Have you ever had a stroke?	**Yes**	**No**

19. **Miscellaneous:**

Have you ever had blood clots in your legs (phlebitis)? Yes No

Have you ever had blood clots in your lungs (Pulmonary embolus)? Yes or No

20. Do you have any history or have you ever been told that you have any anxiety disorder?

Yes No (Panic/anxiety attacks, obsessive compulsive disorder, body dysmorphic disorder?)

21. Do you have sickle cell anemia? Yes No

22. Do you currently have any dental problems (loose tooth, periodontal disease)? Yes No

If yes explain: _____

A. Have you recently had any dental procedures? Yes No

If yes, explain: _____

23. DO YOU HAVE OR HAVE YOU HAD ANY MEDICAL PROBLEMS THAT I HAVE NOT ASKED YOU ABOUT?

If yes, explain: _____

****AN HONEST ANSWER TO THE FOLLOWING QUSTIONS ARE ABSOLUTELY CRUICIAL FOR YOUR SAFTEY DURING ANESTHESIA****

Do you drink Alcohol? Yes or No How often? _____ How much? _____

Do you or have you ever used illegal street drugs? Yes No

If yes explain: _____

"The above information is correct and complete to the best of my knowledge."

**** For Nurse****

Bp: _____ **Patient Signature: _____**

Pulse: _____

Height: _____ **Physician's Signature: _____**

Weight: _____

Checked By: _____