CENTER FOR COSMETIC & RECONSTRUCTIVE SURGERY, P.C.
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NAME:_____ AGE: _____ Today's Date :_____
Reason for consultation: _____
Do you take Aspirin, Advil, Aleve, Motrin, Nuprin, Vitamin E or arthritis medications that can prolong bleeding? If so please list: _____
Do you take any medications? Please list: _____
Do you have any allergies (penicillin, Sulfa, etc): _____

PERSONAL HISTORY: Have you ever had or do you currently have any of the following conditions listed below? You may write in if not listed.

CARDIOVASCULAR:
☐Yes ☐No Angina/Chest Pain
☐Yes ☐No Irregular heart beats
☐Yes ☐No Circulation problems
☐Yes ☐No Edema/Swelling of legs
☐Yes ☐No Heart attacks
☐Yes ☐No Heart failure
☐Yes ☐No High blood pressure
☐Yes ☐No Mitral valve prolapse
☐Yes ☐No Pacemaker
☐Yes ☐No Past cardiac surgery or problems
☐Yes ☐No Valvular disease
☐Yes ☐No Varicose veins

EAR/EYE/NOSE/THROAT
☐Yes ☐No Allergies

☐Yes ☐No Auditory difficulty
☐Yes ☐No Chronic Sinusitis
☐Yes ☐No Sore throat/Canker sores
☐Yes ☐No Ulcers
☐Yes ☐No Visual difficulties

ENDOCRINE
☐Yes ☐No Adrenal gland problems
☐Yes ☐No Diabetes

☐Yes ☐No Thyroid gland problems

GASTRO-INTESTINAL
☐Yes ☐No Hernia
☐Yes ☐No Ulcer
HEMATOLOGIC:
☐Yes ☐No Anemia
☐Yes ☐No Bleeding/Easily bruising
☐Yes ☐No Blood clots/Phlebitis
☐Yes ☐No Prior transfusions/History of Sickle Cell

PULMONARY:
☐Yes ☐No Smoking history _____# pack/day
_____# years
☐Yes ☐No Asthma, last attack
☐Yes ☐No COPD/Emphysema
☐Yes ☐No Cough/Shortness of breath
☐Yes ☐No T.B/Pneumonia

GENITO-URINARY: MALE
☐Yes ☐No Prostate problems
☐Yes ☐No Renal failure

MENSES history: FEMALE
☐Yes ☐No Regular cycle
Date of last period ___/___/_____
Date of last mammogram ____/____/_____

Date of last pelvic exam ____/____/_____
How many pregnancies?
# of pregnancy? _____
# of C-sections _____
☐Yes ☐No Did you breast feed?
☐Yes ☐No Are you currently pregnant?

MALE & FEMALE HISTORY
☐Yes ☐No Have you been tested positive for HIV/Hepatitis?
☐Yes ☐No Do you have any infection now?
☐Yes ☐No Do you drink caffeinated drinks?
How much? _____/day
☐Yes ☐No Do you drink alcohol?
How much? _____/day
☐Yes ☐No Do you use street/IV drugs
What? _____
☐Yes ☐No Have you been addicted?
What? _____
Past surgical history: _____
_____
_____