Patient's Name ________________________________ Chart # _________________ Date ____________________

Age ________ Height ___________ Weight ___________

Weight loss or gain in the past year ______lbs ( ) Loss ( ) Gain Date of last physical exam _________________

Doctor name & address ____

Did it include electrocardiogram? ( ) No ( ) Yes Chest X-ray? ( ) No ( ) Yes

PREVIOUS SURGERY (Please List)

Operation	Year	Hospital	City	Surgeon's Name	Anesthesia (Local or General)

Serious Illnesses (Please List) ____

____

____

MEDICATIONS, DRUGS

Are you allergic to any medicines? No _____ Yes _____

If yes, which one(s)? ____

Please list all medications you are now taking and their dosages, including: birth control pills, diuretics (water pills), blood pressure, or heart medications, tranquilizers, hormones, blood thinners, aspirin, bufferin, etc.

____

____

____

What is your approximate daily consumption of the following:

Coffee or Tea _______________________ Tobacco _________________________ Alcohol _________________

Other intoxicating or mind altering drugs (please specify) ____

List any over-the-counter medications and herbal remedies you currently take ______________________________

____

(OVER)

FAMILY HISTORY

	Age	State of Health
Mother	___	___
Father	___	___
Sister(s)	___	___
Brother(s)	___	___
Children	___	___
___		
___		
___		
___		
___		

Has any relative had:

	No	Yes
Tuberculosis	___	____
Cancer	___	____
Epilepsy	___	____
Heart Disease	___	____
High Blood Pressure ……..	___	____
Lung Disease	___	____
Kidney Disease	___	____
Blood or Bleeding Disorders .	___	____
Asthma	___	____
Mental Disease	___	____

PERTINENT PREOPERATIVE INFORMATION

Question	No	Yes
Have you ever reacted badly to being put to sleep for surgery?	___	____
Has any member of your family ever reacted badly to being put to sleep for surgery?	___	____
Have you required unusually large amount of local anesthetic for medical or dental procedures?	___	____
Have you ever had a bad reaction to a local anesthetic (Novocain, etc)?	___	____
Are you allergic to adhesive tape?	___	____
Are you allergic to suture material such as catgut?	___	____
Have you ever had Scarlet Fever or Rheumatic Fever?	___	____
Do you have hepatitis?	___	____
Do you bleed unusually easily (from cuts, surgery, tooth extractions)?	___	____
Do you bruise easily?	___	____
Have you required transfusion for surgery?	___	____
Are you a slow or poor healer?	___	____
Do you form large scars or keloids?	___	____
Do you have any skin disease, hives, eczema or rash?	___	____
Do you have frequent infections or boils?	___	____
Have you taken steroid medications, cortisone, or ACTH?	___	____
Do you have shortness of breath with walking?	___	____
Does your religion prohibit blood transfusions?	___	____
Do you have, or have you had, any significant emotional problems?	___	____
Have you ever had psychiatric care?	___	____
Have you ever been advised to see a psychiatrist?	___	____
Are you pregnant?	___	____
Do you have food allergies?	___	_____
Do you have family or personal history of DVT - deep venous thrombosis (blood clots)?	___	_____
Do you have family or personal history of anesthesia complications?	___	_____
Do you have sleep apnea?	___	_____
Do you have diabetes?	____	_____
Do you have HIV/AIDS?	____	_____
Do you have high blood pressure?	____	_____

Charlotte Plastic Surgery
2215 Randolph Road
Charlotte, NC 28207
704-372-6846

Signature ____

Relation to Patient ______________________________
(Self, Mother, etc)