LOURDES
Plastic & Reconstructive Surgery

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Certified by the American Board of Plastic Surgery
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PATIENT MEDICAL HISTORY

Patient Name: _____ Today's Date: _____
Last, First M.I.

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Reason for Visit: _____

Primary Care Provider: _____ Office Phone: _____

Address: _____ Office Fax: _____

Referring Provider: _____ Office Phone: _____

Address: _____ Office Fax: _____

Please list any medical illnesses or problems for which you are undergoing treatment:

_____

_____

_____

Please list surgeries you have had and the approximate date:

_____

_____

_____

Please list your current medications and dosages. Please include non-prescription drugs, vitamins, hormones and herbal supplements:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any drug allergies and what reactions you have to these drugs:

_____

_____

Past Medical History: **Have you ever suffered from any of the following? Please circle.**

Stroke	Y	N	COPD	Y	N	Metabolic Syndrome	Y	N
Seizure Disorder	Y	N	Asthma	Y	N	Thyroid Disease	Y	N
Glaucoma	Y	N	Sleep Apnea	Y	N	AIDS or HIV	Y	N
High Blood Pressure	Y	N	Stomach Ulcers	Y	N	Anemia	Y	N
Heart Disease	Y	N	Liver Disease	Y	N	Arthritis	Y	N
Pacemaker	Y	N	Hepatitis	Y	N	Autoimmune Disorder_____	Y	N
Rheumatic Fever	Y	N	Colitis	Y	N	Cancer (what type)_____	Y	N
Mitral Valve Prolapse	Y	N	Vascular Disease	Y	N	Reaction to local anesthetic	Y	N
Tuberculosis	Y	N	Kidney Disease	Y	N	Reaction to general anesthetic	Y	N
Psychiatric Disorder	Y	N	Diabetes	Y	N	Bleeding/Bruising Tendency	Y	N

Review of Systems: **Do you have now or have you had in the last year any of the following?**

Weight loss_____lbs.	Y	N	Chest Pain	Y	N	Poor Wound Healing	Y	N
Weight gain____lbs.	Y	N	Rapid Heart Beat	Y	N	Excessive Scarring	Y	N
Seizures	Y	N	Chronic Diarrhea	Y	N	Frequent Infections	Y	N
Dry Eyes	Y	N	Jaundice	Y	N	Swollen Feet/Ankles	Y	N
Chronic Cough	Y	N	Depression	Y	N	Joint or Muscle Pain	Y	N
Shortness of breath	Y	N	Anxiety	Y	N	Swollen Lymph Nodes	Y	N
Wheezing	Y	N	Skin Rash	Y	N	Bleeding/Bruising	Y	N

Have you ever seen a psychiatrist or counselor? Y N

Are you currently under the care of a mental health professional? Y N

If Yes, may we contact them for assistance with your care? Y N Name:_____Phone:_____

Women: Is there a chance you are pregnant? Y N

Have you taken any of the following in the last 2 weeks?

Aspirin, Bufferin, Anacin	Y	N	Herbal Supplements	Y	N	What kind?_____
Arthritis Medication	Y	N	Cough Medicine	Y	N	
Sedatives	Y	N	Steroids	Y	N	
Vitamin E	Y	N	Diet Supplements	Y	N	
Antibiotics	Y	N	HRT or Birth Control Pills	Y	N	

Date of last physical exam and physician: _____ _____

Social History:

What is your employment? _____

Do you regularly drink six or more cups of coffee per day? Y N

Do you regularly drink alcohol or beer? Y N How much?_____

Do you smoke? Y N How much?_____

What forms of exercise do you do and how many times per week? _____

Family History: Has any blood relative experienced any of the following disorders?

			Who?	What was the problem?
Stroke/Vascular Disease	Y	N	_____	_____
Heart Disease	Y	N	_____	_____
Lung Disease	Y	N	_____	_____
Breast Cancer	Y	N	_____	_____
Skin Cancer	Y	N	_____	_____
Bleeding/Clotting Problems	Y	N	_____	_____

I authorize the administration of blood and blood products in such amounts and at such times as may be deemed advisable in the judgment of Dr. Karen Vaniver and/or her associates or assistants: YES NO

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient's Signature or Patient's Representative: _____ Date: _____