



## MEDICAL HISTORY / REVIEW OF SYSTEMS

Name: \_\_\_\_\_ Sex: M  F  Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Married: Yes  No  Occupation: \_\_\_\_\_ Dominant Hand  
 Right /  Left

**Latex Allergy:** Yes  No  **Tape Allergy:** Yes  No  Specify kind \_\_\_\_\_

**ALLERGIES to FOOD/DRUG:** Yes  No  Please list below, indicating reaction

\_\_\_\_\_

**WHY ARE YOU HERE TODAY?** \_\_\_\_\_

Have you seen another physician for this concern Yes  No  Indicate date/name \_\_\_\_\_

**MEDICATIONS:** List dosage or number of pills per day (use an additional sheet, if necessary)

Prescription Drugs

Non-Prescription (Vitamins; Herbs)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Regular Aspirin Use: Yes  No  Dosage Frequency: \_\_\_\_\_  
NSAID (Advil, Motrin, and Ibuprofen): Yes  No  Dosage / Frequency: \_\_\_\_\_  
Cortisone/Steroid Injections in the Past Year: Yes  No  Date(s) and injection location: \_\_\_\_\_

Smoke: Yes  No  Amount: \_\_\_\_\_ Coffee/Tea/Cola: Yes  No  Amount: \_\_\_\_\_  
Alcohol: Yes  No  Amount: \_\_\_\_\_ Daily Exercise: Yes  No  Amount: \_\_\_\_\_

**FAMILY HISTORY:** Have any blood relatives ever had any of the following problems:

Abnormal Bleeding: Y  N  Diabetes: Y  N  Heart Surgery: Y  N  Tuberculosis: Y  N   
Abnormal Clotting: Y  N  Breast Cancer: Y  N  Heart Attack: Y  N  Kidney Disease: Y  N   
Mental Health Issue: Y  N  Other Cancer: Y  N  Hypertension: Y  N  Other Serious Illness: Y  N

Please describe problems with a **YES** answer:

\_\_\_\_\_  
\_\_\_\_\_

**PERSONAL HISTORY:** Do you currently have or have you ever had:

Abnormal Bleeding: Y  N  Hypertension: Y  N  Slow/Poor Healing: Y  N  Diabetes: Y  N   
Abnormal Clotting: Y  N  Chest Pain: Y  N  Hepatitis: Y  N  Heart Murmur: Y  N   
Anemia: Y  N  Asthma: Y  N  Skin Diseases: Y  N  Other Serious Illness: Y  N   
Thyroid Concerns: Y  N  Heart Attack: Y  N  Heart Surgery: Y  N  Mental Health Issues: Y  N



Please describe all issues answered with **YES**:

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In addition to the items listed above, have you had any medical problems with any of the following:

Head	No <input type="checkbox"/>	Yes <input type="checkbox"/>	please explain _____
Eyes	No <input type="checkbox"/>	Yes <input type="checkbox"/>	please explain _____
Ears/Nose/Throat	No <input type="checkbox"/>	Yes <input type="checkbox"/>	please explain _____
Chest/Heart	No <input type="checkbox"/>	Yes <input type="checkbox"/>	please explain _____
Breast	No <input type="checkbox"/>	Yes <input type="checkbox"/>	please explain _____
Lungs	No <input type="checkbox"/>	Yes <input type="checkbox"/>	please explain _____
GI Tract	No <input type="checkbox"/>	Yes <input type="checkbox"/>	please explain _____
Kidneys/Bladder	No <input type="checkbox"/>	Yes <input type="checkbox"/>	please explain _____
Muscle/Joint/Bone	No <input type="checkbox"/>	Yes <input type="checkbox"/>	please explain _____
Unsightly Scarring	No <input type="checkbox"/>	Yes <input type="checkbox"/>	please explain _____
Immune Diseases	No <input type="checkbox"/>	Yes <input type="checkbox"/>	please explain _____
Other Condition	No <input type="checkbox"/>	Yes <input type="checkbox"/>	please explain _____

Last mammogram \_\_\_\_\_ The results were: Normal  Abnormal

# of children \_\_\_\_\_ / #of pregnancies \_\_\_\_\_

Did you breastfeed? Yes  No  Any chance you may be pregnant? Yes  No

Are you in menopause? Yes  No

Have you ever received a blood transfusion? Yes  No  If yes, what year?

Have you been tested for HIV? Yes  No  If yes, what year? Test results:  Positive  Negative

Do you wear: Contact lenses: Yes  No  Eye glasses: Yes  No  Hearing aid: Yes  No

**SURGICAL HISTORY**, specify year and type of procedures:

	type	date	complications / difficulties
1.	_____		
2.	_____		
3.	_____		
4.	_____		
	_____		



Indicate the type(s) of anesthesia received in the past; list any complications/reactions you experienced.

- Local anesthesia - complications/reactions: \_\_\_\_\_
- General anesthesia - complications/reactions: \_\_\_\_\_
- Spinal/Epidural - complications/reactions: \_\_\_\_\_

Please list any medical conditions you are currently being treated by a physician for:

date treatment began                      physician treating                      briefly describe the condition

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Date last seen by Primary Care Physician: \_\_\_\_\_ Primary Care Physician (name) \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

I certify that the above information is correct and complete to the best of my knowledge. I will not hold my physician or his/her staff responsible for any errors or omissions that I may have made in the completion of this form. This will serve as authorization and consent for examination and treatment.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

<i>For Office Use Only</i> Reviewed by: _____	Date: _____
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Bra size: \_\_\_\_\_

Measurements for Breast Surgery		
	Left	Right
SN-N		
N-IMF		
S-N		
BD		
CD		
WD		
HD		

Implants: \_\_\_\_\_ (left)

\_\_\_\_\_ (right)