

STATESBORO PLASTIC SURGERY- MEDICAL HISTORY

(912) 681-3330

Health Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name

First

Last

Middle

Address

Street

City

State

Zip

Home Phone _____

Email _____

Marital Status: M S D W

Age _____ Sex: M F Date of Birth _____ Occupation: _____

How did you hear about us? _____

Medical History:

Height _____ Weight _____ Current Bra Size _____ (only for breast consults)

Health Problems Past & Present: (mark all that apply)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hepatitis B or C |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Lung/Breathing Problems | <input type="checkbox"/> Bleeding/Clotting Problems | <input type="checkbox"/> Unexpected Weight Loss |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Psychiatric / Depression | <input type="checkbox"/> Presently Pregnant | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Other: _____ | | | |

Please explain all positive responses: _____

Do you smoke? _____ How many packs per day? _____ For how long? _____

(Fill all below- attach additional sheets if necessary)

List all current medications: _____

List all drug allergies: _____

List surgeries and dates: _____

What are you being seen for today? Please be specific _____

If this is the result of an accident, give the date of the injury _____ Describe specifically how the accident occurred:

If the injury is due to a car accident has the auto insurance claim been filed? _____