

southeastern plastic surgery, p.a./southeastern outpatient surgery center

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PATIENT NAME: _____ DATE: _____

REASON FOR VISIT: _____

INFORMATION ON THIS FORM COMPLETED BY: PATIENT PARENT LEGAL GUARDIAN (May need proof of guardianship)

PAST MEDICAL HISTORY - Please check all medical conditions you currently have or have had in the past.

- | | | |
|--|---|------------------------------------|
| None | Sleep Apnea | Diabetes |
| Stroke/Seizure/Epilepsy/Fainting | Chronic Cough/Bronchitis/Pneumonia | Breast Problems |
| Meningitis/Encephalitis | Tuberculosis | HIV positive/AIDS |
| Chest Pain (Angina) | Thyroid Disease | Anemia |
| Heart Disease/Heart Attack | Mononucleosis | Sickle Cell Trait/Disease |
| Irregular Heartbeat | Heartburn/Esophageal Reflux/Hiatal Hernia | Back Pain/Bone/Muscle Problem |
| Heart Murmur/Mitral Valve Prolapse | Stomach Ulcer | Night Sweats |
| High Blood Pressure (Hypertension) | Liver Trouble (Jaundice) | Ankle/Leg Swelling |
| Rheumatic Fever | Kidney/Bladder Problem | TMJ (Difficulty Opening Mouth/Jaw) |
| Sinusitis | Dialysis | Skin problems _____ |
| Asthma/Emphysema/or other Lung problem | Gallbladder Problem | Cancer (Type _____) |
| Other significant Medical Problem(s) _____ | | |

Is there immediate family history related to any of the above conditions? Yes No. If yes, please explain: _____

NAME OF PRIMARY CARE PHYSICIAN AND ALL OTHER PHYSICIANS YOU ARE CURRENTLY SEEING: _____

ALLERGIES – Please list all allergies **and/or** reactions to medications and food (THIS INCLUDES LATEX)

MEDICATIONS – Please list any prescription **and/or** non-prescription medications you are currently taking. (This should include any medication you normally take, but are temporarily not taking)

NAME	DOSE/FREQUENCY	NAME	DOSE/FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Please see reverse)

Label

MD Initials

SURGICAL HISTORY – Please list any procedure performed in a hospital or outpatient surgery setting in which anesthesia was used. START WITH MOST RECENT SURGERY:

DATE	SURGERY	DATE	SURGERY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any complications with surgery ? (i.e. – excessive bleeding) Yes No. If yes, please explain: _____

Any complications with anesthesia? (i.e. – difficulty awakening from surgery, difficulty breathing, nausea/vomiting) Yes No If yes, Please explain: _____

OTHER:

Height _____ Weight _____

Date of last Physical Exam _____ Date of last Tetanus Shot _____
Date of last Mammogram _____ Location _____ Ordering Physician _____

Do you smoke? Yes No If yes, how much? _____ Have you smoked in the past? Yes No If yes, how long? _____

Do you drink alcohol? Yes No If yes, how much? _____

Do you use drugs such as marijuana, cocaine, or heroine? Yes No If yes, how much? _____

Are you currently pregnant or have reason to suspect you are? Yes No Obstetrician _____

Last Menstrual Cycle (Date) _____

Any serious illness during pregnancy? Yes No N/A If yes, please explain _____

Have you ever been under the care of a psychiatrist/psychologist or had counseling? Yes No If yes, please explain _____

Do you have any of the following? (please circle all that apply): Dentures, Loose teeth, Glasses, Contacts, Hearing Aids, Earrings, Body Piercings (Location(s) _____, Prosthesis (type) _____

By signing below, I acknowledge that I understand and have answered the above questions as correctly as possible. I also agree to fully cooperate with all planned and agreed upon care.

Signature _____ Relationship Self Parent Legal Guardian

MD Initials