Plastic Surgery Center, P.A.
Patrick M. Kelley, M.D.
DIPLOMATE OF THE AMERICAN BOARD OF PLASTIC SURGERY
AESTHETIC AND RECONSTRUCTIVE PLASTIC SURGERY

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MEDICAL HISTORY FILE

NAME: _____

DATE: _____

UPDATE: _____

PRESENT PROBLEM:

Give specific problem for which you are seeking plastic/cosmetic surgery:

_____

Have you consulted any other doctors, including plastic surgeons for this condition? _____
If yes, please list their names: _____

_____

Who referred you? _____

SOCIAL:

Age: _____ **Height:** _____ **Weight:** _____ **Sex:** M☐ F☐ **Married:** Y☐ N☐ **Occupation:** _____

Responsible Adult Available to Assist During Recovery Period Y☐ N☐ **Relationship:** _____

HABITS

Smoke: Y☐ N☐ **Amount:** _____ **Coffee/Tea/Cola** Y☐ N☐ **Amount:** _____

Alcohol: Y☐ N☐ **Amount:** _____ **Daily Exercise:** Y☐ N☐ **Amount:** _____

MEDICATIONS:

List dose or number of pills per day, Prescription and Non-Prescription (vitamins & herbs)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Regular Aspirin Use: Y☐ N☐ **Dosage & Frequency:** _____

NSA (Advil, Motrin, Ibuprofen): Y☐ N☐ **Dosage & Frequency:** _____

Cortisone Injections Past Year: Y☐ N☐ **Date(s) and Injection Location:** _____

DRUG ALLERGY: Y☐ N☐ **List drug(s) and type of reaction:** _____

_____

LATEX ALLERGY: Y☐ N☐ **TAPE ALLERGY:** Y☐ N☐

Date Last EKG: _____ **Date Last Chest X-Ray:** _____

PERSONAL PAST HISTORY: Have you ever had:

Abnormal Bleeding	Y☐ N☐	Asthma:	Y☐ N☐	Hypertension:	Y☐ N☐
Abnormal Clotting:	Y☐ N☐	Diabetes:	Y☐ N☐	Sleep Apnea:	Y☐ N☐
Acid Regurgitation:	Y☐ N☐	Fainting Spell:	Y☐ N☐	Snoring:	Y☐ N☐
Anemia:	Y☐ N☐	Heart Attack:	Y☐ N☐	Weight Change Past 12 Mo.:	Y☐ N☐
Angina:	Y☐ N☐	Hepatitis:	Y☐ N☐	Other Serious Illness:	Y☐ N☐

Please describe questions with a "Yes" answer: _____

_____

_____

_____

_____

Have you ever received a transfusion? Y☐ N☐ **If yes, what year?** _____

Do you wear: Contact lenses: Y☐ N☐ **Eye glasses:** Y☐ N☐ **Hearing aid:** Y☐ N☐ **Dentures:** Y☐ N☐

PLEASE COMPLETE REVERSE SIDE

PERSONAL PAST HISTORY: cont'd

Previous Surgery, year and type of procedure: Were you put to sleep? _____

_____

_____

_____

_____

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: _____

Date last seen by Primary Care Physician: _____

Primary Care Physician: Name _____ Telephone (____) _____

Address _____

Family History:

Have any blood relatives ever had the following problems:

Abnormal Bleeding:	Y☐	N☐	Coronary Surgery:	Y☐	N☐	Kidney Disease:	Y☐	N☐
Abnormal Clotting:	Y☐	N☐	Diabetes:	Y☐	N☐	Tuberculosis:	Y☐	N☐
Anesthetic Problems:	Y☐	N☐	Heart Attack:	Y☐	N☐	Other Serious Illness:	Y☐	N☐
Cancer:	Y☐	N☐	Hypertension:	Y☐	N☐			

Please describe questions with a "Yes" answer: _____

_____

_____

_____

_____

SERIOUS INJURIES (i.e. auto accidents, back injuries, neck injuries, etc.)?

Type of injury	Year	After affects, if any
_____	_____	_____
_____	_____	_____
_____	_____	_____

HAVE YOU EVER HAD GLAUCOMA OR SERIOUS EYE / VISUAL PROBLEM? _____

HAVE YOU EVER EXPERIENCED FACIAL PARALYSIS OR PARALYSIS OF ANY EXTREMITY? _____

HAVE YOU EVER HAD SCARLET FEVER? _____

HAVE YOU EVER HAD RHEUMATIC FEVER? _____

HAVE YOU EVER BEEN TOLD THAT YOU HAVE HEART OR LUNG PROBLEMS? _____ IF YES, PLEASE GIVE DETAILS: _____

_____

_____

_____

HAVE YOU EVER HAD ANY SKIN DISEASE, HIVES, ECZEMA OR RASH? _____

HAVE YOU EVER HAD CONVULSIONS OR A SEIZURE DISORDER? _____

DO YOU OR HAVE YOU HAD ANY SIGNIFICANT EMOTIONAL PROBLEM? _____

HAVE YOU EVER HAD PSYCHIATRIC CARE? _____

ARE YOU PREGNANT? _____

ADDITIONAL COMMENTS: _____

_____ _____

PATIENT SIGNATURE RELATIONSHIP, IF SIGNATURE OTHER THAN PATIENT'S