PLASTIC AND HAND SURGERY OF NORTH TEXAS

Date:____________________ MRN#____________________

Patient:______________________________________ Patient Age:_______________

Chief Complaint or Reason for visit____

____

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Do you now or have you ever had any of the following...

MEDICAL HISTORY	Yes	No	Medical History	Yes	No	Medical History	Yes	No
Fatigue			Fibromyalgia			Weight Loss		
Asthma			COPD			Sleep Apnea		
Oxygen Use			Tuberculosis			Acid Reflux		
Hiatal Hernia			Seizure/Blackouts			Migraine		
Hypertension			MRSA			Skin problems		
Heart Failure_____yr			Chest Pain			Palpitations		
Mitral Valve			Coronary Artery			Heart Attack________ *yr*		
Kidney Stones			Renal Disease			Frequent U.T.I.'s		
Hearing Loss			Cataracts			Glasses/Contacts		
Hypo/Hyper-Thyroid			HIV/AIDS			Cancer *type* ____________		
··slood Disorder			Hepatitis A/B/C			Excess bleeding from Surgery		
Phlebitis			Blood Clots			Depression/Anxiety		
Stroke *yr*_______			Diabetic *since:*________			Any Metal in your body		

Please list past Surgeries, Illnesses and Injuries:____

____

____

CURRENT MEDICATIONS

Please list current Medication(s) & Dosage:____

____

____

____

ALLERGIES

MEDICATION ___YES___ NO (if yes, please list below) LATEX__YES __NO IODINE__YES__NO

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Family History:

Anesthesia:________________________ *(relationship)*
Cancer:____________________________*(relationship)*
Heart Disease:______________________*(relationship)*

Bleeding Disorders:__________________*(relationship)*
Diabetes:__________________________*(relationship)*
Other:_____________________________*(relationship)*

Social History:

Alcohol Use: __Daily __Occasionally __Never
Tobacco Use: __Yes __No Type:______ amount per day/wk__________
Illegal Drug Use: __Yes __No