History and Physical
Plastic and Cosmetic Center

Name: _____ **Date:** _____

SOCIAL
Age: _____ 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 Drugs

_____
_____
_____
_____

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 ❑

FAMILY HISTORY: Have any blood relatives every 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: _____
_____

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? _____

Have you been tested for HIV? Y ❑ N ❑ If yes, what year _____ Test results: ❑ positive ❑ negative

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

Previous Surgery, year and type of procedure: _____
_____

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) _____

WOMEN PATIENTS ONLY:
Number of pregnancies _____ Number of children_____ Last menstrual period _____ Did you breast feed? Yes No

Name: _____ **MRN**: _____ **Date:** _____

Completed by Physician

REVIEW OF SYSTEMS

Loose Dental Devices:	Y ❑ N ❑	Chest Pain:	Y ❑ N ❑
Neck Mobility Problem:	Y ❑ N ❑	Irregular Heart Beat:	Y ❑ N ❑
Short Neck:	Y ❑ N ❑	Vomiting:	Y ❑ N ❑
Cough:	Y ❑ N ❑	Difficult Voiding:	Y ❑ N ❑
Shortness of Breath:	Y ❑ N ❑	Seizure:	Y ❑ N ❑
Recent Upper Respiratory Infection:	Y ❑ N ❑	Current Pregnancy:	Y ❑ N ❑
Normal Menstrual Period:	Y ❑ N ❑	Black Out:	Y ❑ N ❑
Stroke:	Y ❑ N ❑	Obesity:	Y ❑ N ❑

Comments: _____
_____
_____
_____

PHYSICAL EXAM
Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Temp: _____

GENERAL STATUS COMMENT
HEENT: _____ Vision: _____ Pharynx: _____ Dental Devices: _____
Pulmonary: _____
Heart: _____
Abdomen: _____
Extremity: _____
Neurologic (if applicable): _____

Comments _____
_____
_____

LABORATORY (if applicable)

H/H:_____	WBC: _____
PT: _____	Chest X-Ray: _____
Mammogram:_____	EKG (Pt over 40):_____
Pregnancy Test:_____	Sodium Chloride: _____
Potassium:_____	CO_2: _____
BUN: _____	Creatinine:_____

Comments _____
_____
_____

DIAGNOSES
1. _____
2. _____
3. _____

ASA CLASSIFICATION
- ❑ P1 A normal healthy patient
- ❑ P2 A patient with mild systemic disease
- ❑ P3 A patient with severe systemic disease
- ❑ P4 A patient with severe systemic disease that is a constant threat to life

FACILITY SELECTED

- ❑ Office-based Surgical Facility
- ❑ Ambulatory Surgery Center
- ❑ Hospital