Name:_____ Date:_____

LoTempio
PLASTIC SURGERY FOR WOMEN

History and Physical

REASON FOR TODAY'S VISIT:

_____

- Please mark if you have had any of the following conditions, even if it was only an acute incident.

Heart Issues:	No _____ Yes_____	Hypothyroidism:	No_____ Yes_____
Poor Circulation:	No_____ Yes_____	Diabetes:	No_____ Yes_____
Bradycardia:	No_____ Yes_____	Breast Cancer:	No_____ Yes_____
Tachycardia:	No_____ Yes_____	Breast Lump:	No_____ Yes_____
A-Fib:	No_____ Yes_____	Migraines:	No_____ Yes_____
Hypertension:	No_____ Yes_____	Stroke:	No_____ Yes_____
Hypotension:	No_____ Yes_____	Nerve pain:	No_____ Yes_____
Bleeding Issues:	No_____ Yes_____	Depression:	No_____ Yes_____
Anemia:	No_____ Yes_____	Anxiety:	No_____ Yes_____
Lung problems:	No_____ Yes_____	Bi-Polar disorder:	No_____ Yes_____
Shortness of Breath:	No_____ Yes_____	Schizophrenia:	No_____ Yes_____
Blood Clots in Lungs:	No_____ Yes_____	Glasses/Contacts:	No_____ Yes_____
Asthma:	No_____ Yes_____	Dry eyes:	No_____ Yes_____
Liver Problems:	No_____ Yes_____	Skin Problems:	No_____ Yes_____
Cirrhosis:	No_____ Yes_____	Eczema:	No_____ Yes_____
Kidney Problems:	No_____ Yes_____	Arthritis:	No_____ Yes_____
Kidney Stones:	No_____ Yes_____	Cancer:	No_____ Yes_____
Re-occurring UTI's:	No_____ Yes_____	Weight Change:	No_____ Yes_____
Kidney Infections:	No_____ Yes_____	Auto-Immune Disorder:	No_____ Yes_____
Renal Disease:	No_____ Yes_____	Congenital Disorder:	No_____ Yes_____

Stomach Problems: No_____ Yes_____

Crohn's/ Ulcerative Colitis: No_____ Yes_____

Hyperthyroidism: No_____ Yes_____

Please list any other medical conditions that you had:

Name:_____ Date:_____

_____

_____

Height: _____ Weight: _____ Breast Size: _____ Latex Sensitivity: No_____ Yes_____

Allergies and Reaction Type:

_____

List any previous surgeries along with the approximate date of surgery:

_____

_____

_____

_____

List all of current medications including over-the-counter, aspirin, herbal supplements, vitamins, and birth control:

_____

_____

History of Smoking: No_____ Yes_____ Quit- Year: _____ Packs per day:_____

Alcohol Consumption: No_____ Yes_____ Quantity per day _____ How many years

_____

Recreational drug use:

_____

Occupation:_____

_____

How many times have you been pregnant? _____ How many times have you carried to term?_____

History of Birth Control Use:_____ How many years:

_____

Most recent PAP smear: _____ Normal/Abnormal:

_____

Mammogram: _____

Results:_____

List any prior problems with anesthesia:

_____

Family Medical History:

_____

_____

_____

Pre-Operative Patient Information: Smoking, second-hand exposure nicotine products (patch, gum, nasal spray). Patients who are currently using tobacco or nicotine products are at a greater risk for significant complication of skin dying and delaying healing. Individuals exposed to second-hand smoke may have significant negative effects on anesthesia and recovery from anesthesia with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine containing products have a significantly lower risk of this type of complication. Please indicate your current status regarding these items below.

_____ I am a non-smoker and do not use nicotine products. I understand the risk of second-hand smoke exposure causing surgical complications.

Name:_____ Date:_____

_____ I am a smoker or use tobacco or nicotine products. I understand the risk of surgical complications due to smoking or the use of nicotine products. I have been informed that I must not smoke, use any nicotine products, and avoid second-hand smoke a month prior to my surgery and one month after my surgery.

_____ I understand a nicotine test will be performed prior to surgery. If positive, surgery will be canceled and/or rescheduled.

Date: _____

Signature:_____