

# 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): \_\_\_\_\_

Last Updated: [\[Insert Date\]](#)

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 <input type="radio"/> N <input type="radio"/>	Chest Pain:	Y <input type="radio"/> N <input type="radio"/>
Neck Mobility Problem:	Y <input type="radio"/> N <input type="radio"/>	Irregular Heart Beat:	Y <input type="radio"/> N <input type="radio"/>
Short Neck:	Y <input type="radio"/> N <input type="radio"/>	Vomiting:	Y <input type="radio"/> N <input type="radio"/>
Cough:	Y <input type="radio"/> N <input type="radio"/>	Difficult Voiding:	Y <input type="radio"/> N <input type="radio"/>
Shortness of Breath:	Y <input type="radio"/> N <input type="radio"/>	Seizure:	Y <input type="radio"/> N <input type="radio"/>
Recent Upper Respiratory Infection:	Y <input type="radio"/> N <input type="radio"/>	Current Pregnancy:	Y <input type="radio"/> N <input type="radio"/>
Normal Menstrual Period:	Y <input type="radio"/> N <input type="radio"/>	Black Out:	Y <input type="radio"/> N <input type="radio"/>
Stroke:	Y <input type="radio"/> N <input type="radio"/>	Obesity:	Y <input type="radio"/> N <input type="radio"/>

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 <sub>2</sub> : _____
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**

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