ALLEGANY PLASTIC SURGERY

Name:_____ **Referring Physician:**_____

Age:_____**Height:**_____**Weight:**_____ **Primary Physician:**_____

DOB: _____**Smoke:** _____**Amount:**_____

Allergies:_____

Current Medications:(Prescriptions, Vitamins, Herbal & Over the Counter)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Previous Surgery/Procedure & Date : _____

_____

_____

Last Mammogram: _____

Do you have Advance Directives: _____ No. _____Yes and a copy was given to Allegany Plastic Surgery on:_____.
I would like to receive information regarding Advance Directives: _____No _____Yes, give on:_____.

Family History:
Has any blood relative ever had any of the following:

Breast cancer..... yes no	High Blood Pressure.....yes no	Kidney Disease ..... yes no	Leg/Blood Clots/DVT..... yes no
Melanoma .....yes no	Heart disease.....yes no	Depression ..... yes no	Pulmonary Embolism..... yes no
Stroke .....yes no	Diabetes .....yes no	Anesthetic Reaction....yes no	Malignant Hyperthermia... yes no

Faith History:
Religion..... yes no. **Would you appreciate prayer for your problem? Yes No**

Past Medical History:
Have you ever had the following:

Heart Disease .....yes no	Cancer..... yes no	Stomach Ulcer..... yes no	Blood Clot ..... yes no
Arthritis .....yes no	Glaucoma ..... yes no	Kidney Disease .... yes no	Pulmonary Embolism .... yes no
Rheumatic Fever.....yes no	Asthma..... yes no	Thyroid Disease... yes no	Alcohol Use.....yes no
Anemia ..... yes no	AIDS or HIV+..... yes no	Bleeding ..... yes no	Drug Use.....yes no
Stroke... ..... yes no	High Blood Pressure. yes no	Tuberculosis ..... yes no	
Diabetes.....yes no	Hepatitis.....yes no	Anesthetic Reaction...yes no	

Review Of Systems: Right or Left Hand Dominant
Do you have now or have you had within the past year:

Weight Change..... yes no	Swollen feet/ankles..... yes no	Seizures..... yes no
Dry eyes ..... yes no	Skin rash ..... yes no	Joint/Muscle Pain... yes no
Chronic Cough ..... yes no	Chronic diarrhea .....yes no	Swollen lymph nodes..... yes no
Jaundice ..... yes no	Easy Bleeding .....yes no	Chest pain .... yes no
Rapid Heart Beat ..... yes no	Depression .....yes no	Easy Bruising .... yes no
Breast lump/discharge .... yes no	Severe muscle pain after exercise .....yes no	Brown colored urine after exercise..... yes no

Reason For this visit:_____

X_____ _____ _____
Signature of Patient or parent if minor Date Physician Signature

****If you have any questions or need any assistance in filling out this form our staff will assist you****