

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
Melanomayes no	Heart disease.....yes no	Depression yes no	Pulmonary Embolism..... yes no
Strokeyes no	Diabetesyes 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 Diseaseyes no	Cancer..... yes no	Stomach Ulcer..... yes no	Blood Clot yes no
Arthritisyes 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 diarrheayes no	Swollen lymph nodes..... yes no
Jaundice yes no	Easy Bleedingyes no	Chest pain yes no
Rapid Heart Beat yes no	Depressionyes no	Easy Bruising yes no
Breast lump/discharge yes no	Severe muscle pain after exerciseyes 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****