**The Plastic Surgery Center** **Summit Medical Group, P.A.**

**Name** ____________________ **Referring Doctor** ________________

**Age** ____________________ **Primary Doctor** ________________

**Reason for visit** ______________________________________________

## Medical History

- ❑ Diabetes
- ❑ History of Stroke
- ❑ Blood related disorders
- ❑ Asthma
- ❑ Thyroid disorder
- ❑ high cholesterol
- ❑ Heart disease
- ❑ High Blood Pressure
- ❑ HIV or Hepatitis
- ❑ Cancer: ______________________
- ❑ Other ________________________

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## Surgical History *(include cosmetic surgery)*

__________________ Date ______

__________________ Date ______

__________________ Date ______

__________________ Date ______

## Health History

- ❑ Easy bruising
- ❑ Excessive bleeding history
- ❑ Chest pain
- ❑ Wheezing
- ❑ Cough
- ❑ Irregular heartbeat
- ❑ Eye problems
- ❑ Hearing problems
- ❑ Shortness of breath
- ❑ Nausea or vomiting
- ❑ Diarrhea or constipation
- ❑ Joint problems / Arthritis
- ❑ Rashes or skin problems
- ❑ Seizure or blackout history
- ❑ Nervousness or depression
- ❑ Urinary problems
- ❑ Recent weight changes

## Allergies

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____________________

**Medications** ______________________________________________

______________________________________________

**Profession** ______________________________________________

**Smoking** ❑ No ❑ Yes (*quantity*) __________________________

**Alcohol** ❑ No ❑ Yes (*quantity*) __________________________

**Family** Mother ❑ Living ❑ Deceased (*cause*): ______________

Father ❑ Living ❑ Deceased (*cause*): ______________

__________________________ ________ __________________________

Patient's Signature Date Physician's Signature