

**BIRMINGHAM INSTITUTE OF PLASTIC SURGERY  
Patient History Form**

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Chart # \_\_\_\_\_

Referred By: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_

**In this time of rapidly expanding medical knowledge and increasing specialization there exists a very real risk of the physician not being aware of the general health and medical background of the patient. Such information may critically affect what procedures we may safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information.**

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please list ALL medications you are currently taking or have taken in the past 6 months (include all prescription drugs, over the counter drugs [Aspirin, ibuprofen, glaucoma drops, pain pills, vitamins, etc])

	<u>Medication Name</u>	<u>Amount</u>	<u>Frequency</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

List all **ALLERGIES** \_\_\_\_\_

Is there a possibility that you are pregnant? Yes No Have you ever used (please circle) LSD, Speed, Cocaine, Marijuana, None  
 Are you a smoker? Yes No How much per day? \_\_\_\_\_ How long have you been smoking? \_\_\_\_\_  
 Ex smoker? Yes No When did you quit? \_\_\_\_\_ How much were you smoking? \_\_\_\_\_  
 How much caffeine per week? \_\_\_\_\_ How much alcohol do you drink per week? \_\_\_\_\_

**Please circle all medical conditions you now have or have had in the past:**

Bleeding Tendency	Hepatitis	Hypertension	Diabetes	Blood transfusions
Glaucoma	Dry Eyes	Cancer	Lung Disease	Asthma/Wheezing
Emphysema	Bronchitis	Irregular Heart Beat	Chest Pain	Heart Disease
Heart Attack	Stroke	Epilepsy	Heart Burn	Intestinal ulcers
Depression	Mental Illness	Drug/Alcohol Addiction	Shortness of Breath	Muscle Spasms

List all previous surgeries (including plastic surgery): 1. \_\_\_\_\_  
 2. \_\_\_\_\_ 3. \_\_\_\_\_  
 4. \_\_\_\_\_ 5. \_\_\_\_\_

Have you ever had Local Anesthetic? Yes No Novocain for dental work? Yes No General Anesthesia? Yes No

Any problems with any type of anesthesia? \_\_\_\_\_

Do you have (circle): Loose/chipped teeth Caps Dentures Contact lenses

Have you ever seen a cardiologist? Yes No Cardiologist Name: \_\_\_\_\_

Date of last EKG: \_\_\_\_\_ Date of Last Mammogram: \_\_\_\_\_

**I verify that the above information is correct.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_