MURPHY PLASTIC SURGERY

PATIENT HEALTH HISTORY

Name: _____ DOB: _____ Age: _____

Gender: M/F Marital Status: S M W D P Height: _____ Weight: _____lbs

Occupation: _____ High Level of education: _____

What brings you in today? _____
_____

MEDICAL HISTORY

Do you currently have or have had in the past? (Check all that apply)

Condition	Yes	No	Condition	Yes	No
Aids(HIV)			Digestion (stomach Ulcers, heartburn, vomiting)		
Arthritis			Ears, Nose, Throat (hearing loss, sinus problems, sore throat		
Asthma			Eyes(glaucoma, macular degenerations)		
Anemia			Heart(murmur, pacemaker, chest pain, irregular heart beat)		
Blackouts/Fainting			Hepatitis		
Bladder problems			High Blood Pressure		
Bleeding problems			Breathing problems		
Blood clots			Neurologic (e.g., numbness, weakness, headaches, paralysis)		
Breast Cancer			Pregnancy		
Skin Cancer			Psychiatric Problems (e.g. depression, anxiety)		
Colon Cancer			Skin problems(e.g. rashes, excessive dryness)		
Lung Cancer			Sexually transmitted disease		
Prostate cancer			Obesity		
Cirrhosis			Osteoarthritis		
COPD(emphysema)			Osteoporosis		
Coronary artery disease			Tuberculosis		
Diabetes			Thyroid disease		
Herpes/Cold sores			Keloid scarring		

Please provide an explanation for any items for which you checked "Yes"
_____
_____
_____

SURGICAL HISTORY

Please list any surgeries you have had, including plastic surgery. Please provide dates and any complications.

_____
_____
_____

Have you ever had any problems/complications related to anesthesia? Yes No
If yes, please explain:
_____

Is there any family history of problems related to anesthesia? Yes No
If yes, please explain: _____

SOCIAL HISTORY

Do you currently smoke? ☒ Yes ☒ No
If yes, how many per day? _____ How many years? _____

If you previously smoke, how long did you smoke? When did you quit?
_____
Do you drink alcohol/beer/wine? ☒ Yes ☒ No
If yes, how much? _____ How often? _____

Do you exercise? ☒ Yes ☒ No
If yes, what type of exercise/how often? _____
_____

Do you have children? ☒ Yes ☒ No
If yes, how many?_____

MEDICATIONS

Please list all medication including dosage and frequency (prescription and/or over the counter) you currently take and the condition for which it is taken.

Medication	Condition	Dosage	Times per day

Do you take aspirin, aspirin containing or non-steroidal medications routinely (including Motrin, Advil, Ibuprofen)? ☒ Yes ☒ No
If yes, which and how often? _____

Are you taking any supplements such as fish oil or herbal supplements? ☒ Yes ☒ No
If yes, which and how often? _____
_____

ALLERGIES

Are you allergic to any medications? ☒ Yes ☒ No
If yes, please list medication and reaction:

Medication	Reaction

Other allergies (such as food or latex): _____
_____

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____