

**Panama City Plastic Surgery**

**History Intake Form**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Race \_\_\_\_\_

Please answer all of the questions as accurately as possible. If you do not understand the question, please ask for assistance.

Primary Care Doctor \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_

Reason for visit: \_\_\_\_\_

List previous surgeries or major illnesses and dates: \_\_\_\_\_

List any medications you are taking, including non-prescription drugs, vitamin, and herbals: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_ Tape allergy YES NO

Currently Smoking: Yes No Quit Smoking: Yes No Date: \_\_\_\_\_ Type & Amount \_\_\_\_\_

Alcohol History: Never Rarely Socially Moderately Daily Type & Amount: \_\_\_\_\_

Do you have any artificial parts (artificial joints, blood vessel, heart valve, pacemaker, etc.)? \_\_\_\_\_

**Past Medical History: (PLEASE CIRCLE EACH ANSWER)**

Have you ever had any of the following?

Heart disease.....	NO	YES	Cancer.....	NO	YES	Stomach Ulcer.....	NO	YES
Arthritis.....	NO	YES	Glaucoma.....	NO	YES	Kidney disease.....	NO	YES
Rheumatic Fever.....	NO	YES	Asthma.....	NO	YES	Thyroid disease.....	NO	YES
Anemia.....	NO	YES	AIDS or HIV..	NO	YES	Bleeding tendency...	NO	YES
DVT (blood clot).....	NO	YES	Stroke.....	NO	YES	Mitral valve prolapse	NO	YES
Diabetes.....	NO	YES	Hepatitis.....	NO	YES	High blood pressure	NO	YES

Other: \_\_\_\_\_

**Review of Systems: (PLEASE CIRCLE EACH ANSWER)**

Do you have now any of the following?

Fever.....	NO	YES	Palpitations.....	NO	YES	Kidney stones.....	NO	YES
Chills.....	NO	YES	Wheezing.....	NO	YES	Edema.....	NO	YES
Night sweats.....	NO	YES	Coughing up blood.....	NO	YES	Back pain.....	NO	YES
Change in weight.....	NO	YES	Painful or difficult swallowing...	NO	YES	Muscle pain.....	NO	YES
Change in vision.....	NO	YES	Nausea.....	NO	YES	Skin rash.....	NO	YES
Discharge from eyes...	NO	YES	Vomiting.....	NO	YES	Hair loss.....	NO	YES
Dry or painful eyes...	NO	YES	Abdominal pain.....	NO	YES	Headaches.....	NO	YES
Sore throat.....	NO	YES	Constipation.....	NO	YES	Confusion.....	NO	YES
Mouth ulcers.....	NO	YES	Diarrhea.....	NO	YES	Falls.....	NO	YES
Nose bleeds.....	NO	YES	Rectal bleed.....	NO	YES	Numbness/tingling.....	NO	YES
Gum bleed.....	NO	YES	Painful/difficult urination.....	NO	YES	Heat/cold intolerance.....	NO	YES
Change in hearing.....	NO	YES	Blood in urine.....	NO	YES	Excessive urination.....	NO	YES
Cough.....	NO	YES	Frequent urination.....	NO	YES	Excessive thirst.....	NO	YES
Chest pain.....	NO	YES	Incontinence.....	NO	YES	Other: _____		

**Family History: (PLEASE CIRCLE EACH ANSWER)**

Breast cancer.....	NO	YES	Hypertension.....	NO	YES	Kidney disease.....	NO	YES
Melanoma.....	NO	YES	Heart disease.....	NO	YES	Depression.....	NO	YES
Stroke.....	NO	YES	Diabetes.....	NO	YES	DVT (blood clot).....	NO	YES

Malignant Hyperthermia.. NO YES Other: \_\_\_\_\_

**Women only:** Could you be pregnant? YES NO Number of pregnancies: \_\_\_\_\_ Did you breast-feed? YES NO  
Number of children: \_\_\_\_\_ Date of last mammogram: \_\_\_\_\_ Breast Lump/Discharge? YES NO

**I verify that the above information is true and accurate to the best of my knowledge**

Patient signature (or parent if minor) \_\_\_\_\_ Date: \_\_\_\_\_