David W. Allison, MD
Plastic and Reconstructive Surgery

HEALTH HISTORY FORM

Patient Name : _______________________ DOB : _______________ AGE : ______ Ht : _______ Wt : _________

Please answer all questions as accurately as possible:

Primary Care Doctor: __________________________ Phone # ______________________________________

Smoking (amt per day): __________________________ Alcohol (type and amt): ________________________

Occupation: ____ Illegal Drug Use : no ______ yes _________

Drug Allergies: ____

Previous Hospitalization and Dates: ____

____

Previous Surgeries and Dates: ____

____

Medications you are taking (prescription, over the counter herbal, vitamins): _______________________

____

Family History: Does anyone in your family have the following? Check if yes.

_____ Breast cancer
_____ Melanoma
_____ Bleeding disorder
_____ Deep vein thrombosis
_____ Heart Disease
_____ Diabetes
_____ pulmonary embolism
_____ Depression

Past Medical History: Have you ever had the following? Check if yes.

_____ Heart disease
_____ Arthritis
_____ Rheumatic Fever
_____ Anemia
_____ Tuberculosis
_____ Mitral Valve Prolapse
_____ Cancer
_____ Glaucoma
_____ Asthma
_____ AIDS/HIV
_____ Thickened scars
_____ High Blood Pressure
_____ Stomach Ulcer
_____ Hepatitis
_____ Stroke
_____ Diabetes
_____ Herpes/cold sores
_____ Blood Transfusion
_____ Kidney Disease
_____ Thyroid Disease
_____ Bleeding tendency

Review of Systems: Do you now or have you had within the past year the Following? Check if yes.

_____ Weight Change
_____ Dry Eyes
_____ Chronic Cough
_____ Jaundice
_____ Rapid heart beat
_____ Swollen feet /ankles
_____ Skin rash
_____ chronic diarrhea
_____ swollen lymph nodes
_____ Depression
_____ Seizures/Epilepsy
_____ Joint/muscle pain
_____ Chest pain
_____ Easy bleeding
_____ Easy bruising

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature: ____ Date : ____________________________