

Revalla Plastic Surgery

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Name _____ Date _____
Last Name First Name Initial

PATIENT HEALTH INFORMATION

Birth Date _____ Age _____ Sex _____ Height _____ Weight _____

Marital Status _____ Occupation _____

Primary Care Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Referring Physician (if applicable) _____ Phone _____

Address _____ City _____ State _____ Zip _____

Reason(s) for which you are seeking consultation (check all that apply)

Aesthetic/Cosmetic Surgery

- Breast Enlargement
- Breast Lift
- Breast Revision
- Breast Reduction
- Abdominal (Tummy) Tuck
- Other _____
- LipoSelection/Liposuction
- Botox
- Fillers(Restylane, Scuptra)
- Facial Rejuvenation
- Eye/Brow Lifting

Reconstructive Surgery

- Breast Reconstruction
- Skin Cancer/Lesion/Scar
- Head/Face/Hand Injury
- Burn Injury
- ER Follow-up

Have you seen another doctor(s) for this reason? Yes No

If yes, who have you seen _____ When _____

Past Medical History - Have you been diagnosed with any of the following health problems? (check all that apply)

- Eye Problems
- Ear/Hearing Problems
- Nose Problems/Sinusitis
- Herpes/Cold Sores/ Fever Blisters
- Migraines
- Head Injury/Concussion
- Stroke/Seizures
- Anxiety/Depression
- Mental Illness
- Asthma/Lung Problems
- Emphysema
- Pneumonia
- Tuberculosis (TB)
- Persistent Cough
- Heart Attack/Disease
- Heart Murmur/Rheumatic Fever
- Chest Pain
- High Blood Pressure
- Bleeding Disorder
- Blood Clots/DVT
- Diabetes/Low Blood Sugar
- Thyroid Problems
- Anemia
- Liver Problems/Hepatitis/ Jaundice
- Abdominal/Digestive Problems
- Ulcers/Reflux
- Urinary Problems/Kidney Infections or Stones
- Breast Masses
- Heavy Scarring Problems
- Broken/Cracked Bones
- Dislocations
- Arthritis/Joint Problems
- Back Problems
- Fibromyalgia
- Lupus/Scleroderma
- Autoimmune Disease
- AIDS/HIV
- Cancer, Type: _____
- Taken Fen Phen

Health History - Complete the following

List the dates of your most recent:

Physical Exam _____ Normal? Yes No
Blood work/Labs _____ Normal? Yes No
EKG _____ Normal? Yes No
Chest x-ray _____ Normal? Yes No
Other: _____ Normal? Yes No

Do you regularly exercise? Yes No

If yes, what do you do? _____

How often? _____

For how long? _____

Since when? _____

Past Surgical History - List all prior surgical procedures including minor, elective, and cosmetic surgery

If you have had surgery, check type(s) of anesthesia you received and circle any problem(s).

- General Anesthesia Nausea / Vomiting / Slow Awakening / Difficult Intubation / Other _____
- IV Sedation Nausea / Vomiting / Slow Awakening / Other _____
- Epidural/Spinal Nausea / Vomiting / Insufficient / Bleeding / Headache / Other _____
- Block Insufficient / Prolonged / Systemic Reaction / Other _____
- Local Insufficient / Heart Palpitations / Systemic Reaction / Other _____

Allergies - (check all that apply):

- Antibiotics
- Penicillin
- Mycins
- Sulfa
- Aspirin
- Codeine
- Morphine
- Adhesive
- Cosmetics
- Latex
- Other(s) _____
- None

Current Medications - (Check and add all that apply)

| <u>Prescription Medications</u> | <u>Pain Relievers</u> | <u>Vitamins</u> | <u>Herbal Supplements</u> | |
|---------------------------------|---|--|-------------------------------------|---|
| _____ | <input type="checkbox"/> Aspirin (Bayer, Excedrin, etc) | <input type="checkbox"/> Multi-vitamin | <input type="checkbox"/> Diet Pills | <input type="checkbox"/> Kava-kava |
| _____ | <input type="checkbox"/> Ibuprofen (Advil, Motrin, etc) | <input type="checkbox"/> Vitamin C | <input type="checkbox"/> Echinacia | <input type="checkbox"/> Licorice |
| _____ | <input type="checkbox"/> NSAIDS (Aleve, etc) | <input type="checkbox"/> Vitamin E | <input type="checkbox"/> Ephedra | <input type="checkbox"/> Metabo-Life |
| _____ | <input type="checkbox"/> Other(s): _____ | <input type="checkbox"/> Other(s): _____ | <input type="checkbox"/> Feverfew | <input type="checkbox"/> SawPalmetto |
| _____ | _____ | _____ | <input type="checkbox"/> Garlic | <input type="checkbox"/> Soy |
| _____ | _____ | _____ | <input type="checkbox"/> Ginseng | <input type="checkbox"/> St. Johns Wort |
| _____ | _____ | _____ | <input type="checkbox"/> Ginko | <input type="checkbox"/> Valerian |
| _____ | _____ | _____ | <input type="checkbox"/> Goldenseal | _____ |

For Women Only - Complete the following

| | |
|---|--|
| Age at 1 st menstrual period _____ | Have you breast fed? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Age at 1 st pregnancy _____ | Do you use birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Number of pregnancies? _____ | Date of last menstrual cycle _____ |
| How many live births? _____ | Date of most recent pap smear _____ Normal? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| How many cesareans? _____ | Date of most recent mammogram _____ Normal? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Social History - Complete the following

Do you smoke? Yes No If yes, _____ packs per day for _____ years

Have you ever smoked? Yes No If yes, when did you quit? _____ and how much did you smoke? _____ packs per day for _____ years

Do you use recreational drugs? Yes No If yes, please list _____

Do you drink alcohol? Yes No If yes, _____ drinks per day/week

Family History - (check all that apply)

- Blood Clots
- Bleeding Disorder
- Stroke
- Asthma
- Heart Disease
- High Blood Pressure
- Diabetes
- Reflux Disease
- Ulcers
- Thyroid Problems
- Arthritis/Joint Pain
- AIDS/HIV
- Breast Cancer Who? _____
- Other Cancers What? _____
- Other _____

Signature of Patient Date _____

Signature of Physician Date _____
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