Murphy PLASTIC SURGERY
DEFINING EXCELLENCE

Patient Medical History

Name: _____ **Date of Birth:** _____

Please tell us what procedures you are interested in:

_____

_____

Height: _____ **Weight:** _____

Do you Smoke? □ No □ Yes, How many packs per day? _____

How much alcohol do you drink?
□ none □ occasional □ social □ daily □ more than 2 drinks a day
□ more than 7 drinks a day

Do you have any allergies? Please list the medication or allergen and type of reaction:

1. _____
2. _____
3. _____
4. _____
5. _____

Are you currently taking any vitamins, minerals or supplements?
□ No □ Yes, (please list type and dosage)

1. _____
2. _____
3. _____
4. _____
5. _____

Are you currently taking any medications? □ No □ Yes, (please list type, dosage & frequency)

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have a history of any of the following bleeding problems?
□ easy bleeding □ Von Willebrands □ hemophilia □ excessive clotting
□ history of DVT □ history of PE □ anemia □anticoagulation
□ other _____

Do you have problems with chronic dry eye which requires eye drops? □ No □ Yes
Have you had Lasik surgery within the last six months? □ No □ Yes
Do you wear contact lenses? □ No □ Yes

Have you had a history of any of the following?

General History:
□ recent weight gain □ recent weight loss □ poor nutrition □chronic fatigue
□ other _____

Psychiatric/ Neurologic History:
□ seizures □ depression □ anxiety □ fibromyalgia □other _____
Ear/Nose/Throat History:
□ blepharospasm □hearing loss □ wear glasses □ vision loss □ snoring/apnea □ other_____
Cardiac History:
□ HTN □ hyper cholesterol □ CHF □ myocardial infarction □ arrhythmias □ pacemaker
□ mitral valve prolapse □ other _____
Pulmonary History:
□ asthma □ PTX □ COPD □ emphysema □ other _____ ☐ Sleep Apnea ☐ Use CPAP
Hepatic History:
□ Hepatitis A □ Hepatitis B □ Hepatitis C □ cirrhosis □jaundice
□gall stones □ other _____
Renal History:
□ kidney stones □ renal insufficiency □ renal failure □ pyelonephritis
□ urinary tract infection □ other _____
Gastrointestinal History:
□ bleeding ulcers □ constipation □ diverticulosis □ GERD
□ non-bleeding ulcers □ hemorrhoids □ irritable bowel □ other _____
Pregnancy history:
□ vaginal delivery, how many? _____ □ C-section delivery, how many? _____
□ recurrent UTI □ incontinence □ urethral stricture □ other _____
Extremity History:
□ varicose veins □ chronic edema □ ulcers □ difficulty walking □ other _____
Breast History:
□ breast mass, left or right □ nipple discharge, left or right □ history of breast feeding
□ intertriginous rashes □ other _____
Endocrine History:
□ Diabetes, diet controlled □ diabetes, oral medication
□ diabetes, insulin dependent □ hyperthyroid □ hypothyroid □ other _____
Infectious Disease History:
□ HIV □ oral herpes □ genital herpes □ genital warts □ other _____
Anesthesia History:
□ difficult intubation □ difficult extubation □ post-op nausea/vomiting
□ malignant hypothermia □ other _____
Cancer History:
□ skin □ breast □ lung □ liver □ colon □ other _____
Other Health History Not Mentioned Above: _____
_____

Does anyone in your family have a history of the following?
□ abnormal bleeding □ anesthesia problems □ autoimmune disorders □ cancer
□ diabetes □ heart disease □kidney disease □ liver disease □ lung disease
□ endocrine disease □ other _____

Past Surgical History:
Cosmetic Surgery type and date: _____
_____
_____
_____

Other Surgeries type and date: _____
_____
_____

_____ _____
Patient's Signature Date