NEW LEAF PLASTIC SURGERY- FORT WORTH

817-380-1087

Health Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient:

Chief complaint (what is the reason for today's visit):_____

Please List Any and All Allergies (Please describe what the reaction was):

_____

_____

Please List Any Medications That You Are Currently Taking (Please include dosage if known):

_____

_____

Do You take Any Vitamins or Minerals: No ___ Yes___ (If you answered yes please list them below)

_____

PAST MEDICAL HISTORY

Patient denies any past medical history	Yes	No	High Cholesterol	Yes	No
Abdominal Bleeding	Yes	No	Kidney Stones	Yes	No
Asthma	Yes	No	Hives	Yes	No
Blood Clots	Yes	No	Neurofibromatosis	Yes	No
Breast Cancer	Yes	No	Skin Cancer	Yes	No
Cancer	Yes	No	Skin Disorder	Yes	No
Carpal Tunnel Syndrome	Yes	No	Stroke	Yes	No
Chest Pain/Tightness	Yes	No	Thyroid Disease	Yes	No
COPD/Emphysema	Yes	No	Trigger Finger	Yes	No
Diabetes	Yes	No	Tuberculosis	Yes	No
Eczema	Yes	No	Ulcers	Yes	No
Heart Disease	Yes	No	X-ray Therapy	Yes	No
Heart Murmur	Yes	No	Chemotherapy	Yes	No
Hepatitis	Yes	No	Peripheral Vascular Disease	Yes	No
High Blood Pressure	Yes	No			

Please List Any and All Past Surgery (Please include the name of the procedure, date of procedure and any complications that you may have encountered):

_____

_____

ANESTHESIA HISTORY

Patient denies any past anesthesia problems	Yes	No
Never received general anesthesia	Yes	No
Difficult Intubation	Yes	No
Difficult Extubation	Yes	No
Malignanat Hyperthermia	Yes	No
Post op nausea and /or vomiting	Yes	No
Local anesthesia complications	Yes	No

ANESTHESIA COMPLICATIONS

Allergic reaction	Yes	No
Difficulty waking up	Yes	No
Nausea	Yes	No
Sensitivity to Anesthesia Agent	Yes	No
Vomiting	Yes	No

FAMILY HISTORY

Denies any family history	Yes	No	Abnormal clotting	Yes	No
Abnormal Bleeding	Yes	No	Anesthesia Problems	Yes	No

DO YOU NOW OR HAVE YOU EVER HAD…….. (You must circle an answer for each individual item)

Good health lately	Yes	No	Eyes normal	Yes	No
Recent weight gain	Yes	No	Generally good vision	Yes	No
Recent weight loss	Yes	No	Eye disease/injury	Yes	No
Fever	Yes	No	Wears glasses/contacts	Yes	No
Fatigue	Yes	No	Blurred or double vision	Yes	No
Headache	Yes	No	Glaucoma	Yes	No
Ear/nose/throat normal	Yes	No	Respiratory normal	Yes	No
Hearing loss	Yes	No	Frequent cough	Yes	No
Ringing in the ears	Yes	No	Spitting up blood	Yes	No
Earaches/drainage	Yes	No	Shortness of breath	Yes	No
Sinus problems	Yes	No	Asthma/wheezing	Yes	No
Nose bleeds	Yes	No			
Mouth sores	Yes	No	Genitourinary normal	Yes	No
Bleeding gums	Yes	No	Frequent urination	Yes	No
Bad teeth	Yes	No	Burning or painful urination	Yes	No
Sore throat/voice changes	Yes	No	Blood in urine	Yes	No
			Change of force of strain when urinating	Yes	No
Gastrointestinal normal	Yes	No	Incontinence or dribbling	Yes	No
Loss of appetite	Yes	No	Kidney stones	Yes	No
Change in bowel movements	Yes	No			
Nausea/vomiting	Yes	No	Musculoskeletal normal	Yes	No
Frequent diarrhea	Yes	No	Joint pain	Yes	No
Painful bowel movements/constipation	Yes	No	Joint stiffness/swelling	Yes	No
Blood in stool	Yes	No	Weakness of muscles/joints	Yes	No
Stomach pain	Yes	No	Muscle pain/cramps	Yes	No
			Back pain	Yes	No
Hematologic/lymphatic normal	Yes	No	Cold extremities	Yes	No
Slow to heal after cuts	Yes	No	Difficulty walking	Yes	No
Bruise/bleed easily	Yes	No			
Anemia	Yes	No	Neurological normal	Yes	No
Phlebitis	Yes	No	Frequent/recurring headaches	Yes	No
Past transfusion	Yes	No	Light headed/dizzy	Yes	No
Enlarged glands	Yes	No	Convulsions/Seizures	Yes	No
			Numbness/tingling sensations	Yes	No
Skin normal	Yes	No	Tremors	Yes	No
Rash or itching	Yes	No	Paralysis	Yes	No
Change in skin color	Yes	No	Stroke	Yes	No
Change in hair or nails	Yes	No			
Varicose veins	Yes	No	Endocrine normal	Yes	No
			Glandular/hormone problem	Yes	No
Psychiatric normal	Yes	No	Thyroid disease	Yes	No
Memory loss/confusion	Yes	No	Excessive thurst/urination	Yes	No
Nervousness	Yes	No	Heat/cold intolerance	Yes	No
Depression	Yes	No	Dry skin	Yes	No
Sleep problems	Yes	No	Change in hat/glove size	Yes	No
Cardiovascular normal	Yes	No	Allergic/immunologic normal	Yes	No
Heart trouble	Yes	No	Environmental allergy	Yes	No
Chest pain	Yes	No	Sneezing fits	Yes	No
Sudden heart beat changes	Yes	No			
Swelling in hands or feet	Yes	No			

Autoimmune Disorders	Yes	No	High blood pressure	Yes	No
Breast Cancer	Yes	No	Hemophilia	Yes	No
Cancer	Yes	No	Kidney disease	Yes	No
Cleft lip	Yes	No	Liver disease	Yes	No
Cleft Palate	Yes	No	Lung disease	Yes	No
Diabetes	Yes	No	Malignant hyperthermia	Yes	No
Drug allergies	Yes	No	Skin cancer	Yes	No
Endocrine disease	Yes	No	Skin disease	Yes	No
Hearing loss	Yes	No	Substance Abuse	Yes	No
Heart disease	Yes	No	Von Wilebrand	Yes	No

Do you drink alcohol? ❒ Yes ❒ No
If so, how much?_____

Do you smoke? ❒ Yes ❒ No If so, how much? _____ For how long? _____
When did you quit?_____

Do you have a history of sexually transmitted diseases, and if so, what kind?_____
Type of treatment for this?_____

Tanning History (Please Check One)

	Always burns, never tans
	Always burns, tans with difficulty
	Burns mildly, tans slowly
	Rarely burns, tans with ease
	Very rarely burns, tans very easily
	Never burns, tans very easily

Do you use tanning beds? □ Yes □ No

Ability To Heal

Does your skin appear fragile, burns easily?	Yes	No
Do you form thick or raised scars from a cut or burn?	Yes	No
Do you wax or use hair removal creams?	Yes	No
Do you ever get cold sores?	Yes	No

Do you exercise? □ Yes □ No If yes, how much?_____

Female Questions

	Yes	No	N/A	Details
Do you have regular periods?				
Are you going through menopause?				
Are you pregnant or lactating?				
During pregnancy, did you ever get hyperpigmentation or masking?				
Do you have children? How many?				
Age of menarche?				

When was your last eye examination? _____ By whom? _____

When and where was your last chest x-ray? _____ EKG? _____

Who is your personal physician, if any? _____Please list all physicians presently caring for you.

_____

Have you ever been under psychiatric care? ❒ Yes ❒ No When? _____Why? _____

Have you had any recent blood work done? ❒ Yes ❒ No Where? _____

Is there anything else you think the doctor should know? _____

_____

By signing below, I agreee that the above information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____