Past Medical History and Health Assessment Form

Plastic Surgery
Joseph Daw, MD

Full Name:
Phone (home):
Phone (work):
Phone (mobile):
Email (priority):
Preferred Contact (please circle one): Home, Work, Mobile, Email
SSN (last 4 digits):
Primary Care Physician: **PCP Phone:**
Who referred you or how did you become aware of Dr. Joseph Daw's practice?

What specific aesthetic concerns are you interested in discussing at Consultation?

Thank you for choosing to visit with Dr. Joseph Daw, Lori Anderson and the staff at the Institute of Aesthetic Surgery today. As part of our efforts to provide excellent care for you, we need your help in understanding your complete medical history. The questions on this form will assist us in giving you the best care possible. If you have any difficulties reading, writing, seeing, communicating or understanding that may require assistance, please ask for help and check here ☐. If you are unsure how to answer a question, please ask the Patient Coordinator, Nurse or Doctor during your visit.

Past Medical History

Please list all current and previous medical illnesses and problems: If none, please check here ☐

1		5	
2		6	
3		7	
4		8	

If you choose not to disclose any medical history it could affect your surgical outcome.

Initials: __________

Medications

Please list all current medications (prescription, over the counter and herbal): If none, please check here ☐

	Name	Dosage	Times Per Day	Reason For Taking Medication
1				
2				
3				
4				
5				
6				
7				
8				

If you choose to NOT disclose any prescription, over-the-counter or herbal medications it could affect your surgical outcome.

Initials: __________

Past Surgical History

Please list all past surgeries: If none, please check here ☐

	Operation	Year	Surgeon
1			
2			
3			
4			
5			

If you choose not to disclose any surgical history it could affect your surgical outcome.

Initials: __________

Have you or any family member ever had problems or complications with any local or general anesthesia? Please explain:

Have you or any family members ever had problems or complications with excessive bleeding or a known blood clotting disorder? Please explain:

Are you pregnant, planning for impending pregnancy or is there any possibility that you may currently be pregnant?

ALLERGIES

Please list any medication allergies: ______________________________ If none, please check here ☐

Please list any food or environmental allergies: ______________________ If none, please check here ☐

Please check if you are allergic to any of the following: ☐Latex ☐Tape ☐Shellfish ☐Iodine contrast/dye

SOCIAL HISTORY

Marital status ☐Single ☐Married ☐Divorced ☐Widowed

Occupation: ______________________ Employer: ______________

Do you currently smoke? ☐Yes ☐No If yes, how many? ______packs/day. How long? ___years.

Have you ever smoked? ☐Yes ☐No How many? _____packs/day. How long? _____years. When did you quit? ______.

How many alcoholic drinks do you drink per week? ______________drinks/week.

Do you currently use or have you ever used cocaine, heroin, intravenous or other illegal drugs? ☐Yes ☐No

FAMILY HISTORY

Please list any medical diseases in your immediate relatives, including cancer:

Mother/Father: ______________________________

Brothers/Sisters: ______________________________

Children: ______________________________

OVERVIEW OF YOUR CURRENT HEALTH

Please check yes or no if you experienced any of the symptoms or problems listed below:

Y	N	
☐	☐	Fevers or chills
☐	☐	Weight loss
☐	☐	Sweats
☐	☐	Fatigue
☐	☐	Visual problems
☐	☐	Asthma, breathing or lung problems
☐	☐	Chest pain
☐	☐	Heart problems (heart attack, pacemaker…)
☐	☐	Stroke or headache problems
☐	☐	Blood pressure or circulation problems
☐	☐	Blood or lymph node diseases
☐	☐	Excessive or abnormal bleeding
☐	☐	Stomach or digestive problems (ulcer, heartburn…)
☐	☐	Sleep or snoring problems

Y	N	
☐	☐	Bone, muscle or joint problems
☐	☐	Depression, anxiety or mental illness
☐	☐	Skin conditions, growths or cancers
☐	☐	Allergy or immune problems
☐	☐	Kidney, bladder or urination problems
☐	☐	Sexual, gynecologic, or testicular problems
☐	☐	Seizure, nerve or brain disorders
☐	☐	Thyroid, endocrine or hormone disorders
☐	☐	Tuberculosis or infectious disease
☐	☐	HIV or AIDS
☐	☐	Hepatitis A, B or C
☐	☐	Excessive scarring
☐	☐	Recent dental work
☐	☐	Do you have any other conditions or problems

Please explain if you answered yes to any of the above: ______________________________

____

____

____

____

Height ____' ____"

Weight ________**lbs**

I understand that all specific information for my informed consent for proposed procedures or treatments will be provided under separate cover after review of this information by Sigalove, MD.and his staff. I understand the above questions and have answered the questions as accurately and truthfully as possible. I understand that incomplete information may compromise my medical care and I agree to provide updated information to the physician if and when my medical information changes or is requested of me by or his staff.

Patient/Guardian Signature **Date**

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