PLASTIC SURGEONS OF LEXINGTON, PLLC
PATIENT HISTORY FORM

Today's Date: ____________________

Name: ________________________ Birthdate: ______________

Name of family physician: ____

Why are you being seen today? ____________________________________

____

Approximate date symptoms began: ___________________________________

Do you have any of these problems currently?	Yes	No	If Yes, please explain
Cardiovascular (heart)			
High blood pressure			
Respiratory (lungs/breathing)			
Gastrointestinal (stomach/intestines)			
Musculoskeletal (muscle/bone/arthritis)			
Dermatologic (skin)			
Neurological (stroke/epilepsy/etc)			
Endocrine (thyroid/diabetes)			
Hematologic (blood/lymph nodes)			
Psychiatric			

Infection History

Previous Surgeries	Physician	Year

Family History

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Mother				
Father				

Do you know of any blood relative who has or has had: (How are they related to you?)

Cancer		Heart Disease	
Bleeding Tendency		Gallstones	
High Blood Pressure		Asthma	
Liver Disease		Alcoholism	
Tuberculosis		Leukemia	
Diabetes		Stroke	
Colitis		Kidney Disease	

Social History

Marital Status: ______

Currently Employed? ______ Student? ______

Do you use tobacco? ______ How much? ______

Do you drink alcohol? ______ How much? ______

Current Medications	Dose; including strength and number of pills per day

Food Allergies	Reaction

Drug Allergies	Reaction

Environmental Allergies	Reaction