PLASTIC SURGEONS OF LEXINGTON, PLLC
PATIENT HISTORY FORM

1400 Harrodsburg Rd. Suite B-75, Lexington

Today's Date: ___________________________

Name: __________________________________ Birth date: ___________________

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				

Name: ______________________________ Birth date: __________________

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 smoke? ______________________________Have you ever smoked? ______________

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

Please Enter:

HT: _____________

WT: _____________