PLASTIC SURGEONS OF LEXINGTON, PLLC
PATIENT HISTORY FORM

Today's Date: _____

Name: _____ Birthdate: _____

Why are you being seen today? _____

Please check or circle any conditions that you have or have had:

Aneurysm__	Chronic Constipation__	Fibromyalgia__	PTSD__
Bacterial Endocarditis__	Chronic Diarrhea__	Implants___	Bowel Obstruction__
Cardiac Stent__	Celiac Disease__	Stimulators__	Back Pain__
Cardiomyopathy__	Cirrhosis of Liver__	Pain Pump__	Schizophrenia__
Angina__	GERD__	Spinal Cord Injury__	Blood Transfusion___
Congestive Artery Disease__	Cystic Fibrosis__	Bipolar Disorder__	Bleeding Disorder__
Congenital Heart Defect__	Hepatitis__	Sickle Cell Anemia____	Thrombocytopenia__
Heart Valve Problems__	Gastritis__	Diabetes__	Anemia__
High Blood Pressure__	Hiatal Hernia__	Thyroid Disease__	Lupus__
High Cholesterol__	Irritable Bowel __	Alzheimer's__	Immunosuppression__
Pacemaker/Defibrillator__	Traumatic Brain Injury__	Cancer___	Spina Bifida__
Cardiac Arrhythmia__	Pancreatitis__	Cerebral Palsy__	Heart Murmur__
Peptic Ulcer__	Concussion__	Seizures__	Heart Attack__
Colostomy/Ileostomy__	Dementia__	Stroke__	Peripheral Vascular Disease__
Diverticulitis__	Migraine__	Sleep Apnea__	Peripheral Neuropathy __
Syncope (fainting)__	Lymphoma__	Blood Clots__	Asthma__
Hodgkin's__	Parkinson's___	Frequent Bronchitis__	Pneumonia__
Kidney Disease__	Muscular Dystrophy__	Multiple Sclerosis__	Heart Cath__
Infectious diseases__	Tuberculosis__	Arthritis___	Recent EKG __
COPD__	Depression__	Blood Clot in Lung(s)__	Cardiac Clearance __
Heart Echo __	Stress Test __	Atrial Fibrillation__	Home Oxygen__
Chronic Cough__	Fatty Liver __	Anxiety__	Skin Cancer __

OTHER (Not Listed) _____

Any cardiac event, please list: _____

All Current Physicians: _____
_____

Have you been on any steroids or immunotherapy in the last year: _____ Yes _____ No

Name: _____ Birthdate: _____

Previous Surgeries	Physician	Year

Marital Status: _____
Do you smoke nicotine products? _____ Have you ever smoked? _____
Do you drink alcohol? _____ How much alcohol? _____
Do you smoke electronic cigarettes/vape/dip? ____ Yes ____ No

HT: _____ WT: _____

Current Medications	Dose; including strength

Drug Allergies	Reaction

Do you have an allergy to Latex? _____Yes ____ No

What additional services would you like to learn about? Please check all that apply

○ Dysport/Botox/ Fillers	○ Browlift	○ Breast Size
○ Skin Care Products	○ Drooping Eyelids	○ Breast Shape
○ Body Contouring	○ Under Eye Bags	○ Breast Implant Correction
○ Thin Lips	○ Facial Wrinkles/ Sagging	○ Breast Reconstruction
○ Eyelash Fullness or Thickness	○ Mole Removal	○ Tummy Tuck
○ Spider Veins	○ Ear Size/ Shape	○ Upper Arm Lift
○ Facial Redness	○ Microneedling	○ Thigh Lift
○ Surgery After Massive Weight Loss	○ Hand Rejuvenation	○ Butt Lift
○ Age Spots/ Freckles	○ Red or Raised Scars	○ Liposuction
○ Laser Treatments for Pigment, Broken Vessels,Collagen Remodeling		

Name: _____ Birthdate: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ON A SCALE OF 1 TO 5 BY CIRCLING THE APPROPRIATE NUMBER

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		True Age		Older Than
1	2	3	4	5

When I look in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

My Time Frame for Surgery Is:

____ As Soon As Possible ____ 1 to 3 Months ____ 3 to 6 Months

____ 6 to 12 Months ____ Just Need Information