PLASTIC SURGEONS OF LEXINGTON, PLLC
PATIENT HISTORY FORM

Today's Date: _____

Name: _____ Birthdate: _____

Name of family physician: _____

Why are you being seen today? _____

Current or Previous Health Problems	Self Yes	No	Problem	Family--Problem
Cardiovascular (heart attack/afib/stent/bypass)				
High blood pressure				
Respiratory (lungs/asthma/emphysema/other)				
Gastrointestinal (stomach/intestines)				
Musculoskeletal (muscle/bone/arthritis)				
Dermatologic (skin)				
Neurological (stroke/epilepsy/etc)				
Endocrine (thyroid/diabetes)				
Hematologic (blood/lymph nodes)				
Psychiatric (depression/anxiety/etc)				
Vascular disease (arteries/veins/lymph nodes)				
Autoimmune Disease (R/A/lupus/etc)				
Cirrhosis/fatty liver				
Kidney/renal issues				

HT: _____ WT: _____

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

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/ or vape? ____ Yes ____ No

Current Medications	Dose; including strength