Mercy Clinic
Facial Plastic Surgery

NAME_____
Date of Birth _____

Patient History Form

OFFICE USE ONLY
B/P: _____/_____ B/P: _____/_____
B/P: _____/_____

REASON FOR TODAY'S VISIT: _____

HEIGHT: _____ WEIGHT: _____

Do you have any drug allergies? YES NO **Do you have any food or seasonal allergies?** YES NO

Do you have a known latex allergy? YES NO **Are you still having periods?** YES NO
Are you pregnant? Y / N Date of Last Period_____

If yes, please list drug and reaction:

_____ _____
_____ _____
_____ _____

If yes, please list food and reaction:

_____ _____
_____ _____
_____ _____

MEDICATIONS

Please list **any** current ***herbs, vitamins, or prescription/non-prescription medications*** you are taking and the ***dosage and frequency*** if possible:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

MEDICAL HISTORY

Have you ever had a cold sore? Yes No

Have you ever had MRSA/Staph Infection Yes No Details:_____

	Yes	No		Yes	No		Yes	No
No Significant Medical History			**Cancer**			**Heart Disease**		
High Cholesterol			**Thyroid Disease**			**Hepatic Disease**		
Hepatitis			**Hypertension/High Blood Pressure**			**Cerebrovascular Disease**		
HIV/AIDS			**Diabetes Last HgA1c:**			**Anesthetic Complications**		
Bleeding Disorder			**Asthma**					

SURGICAL HISTORY (also include cosmetic procedures and year of surgery)

_____ _____
_____ _____
_____ _____

FAMILY HISTORY

Marital Status:
Single Married Divorced Widow(er)

Children:
Yes No #_____

Occupation:_____

Please Circle All That Apply:

Constitution:	**Eyes:**	**Endocrine:**	**Allergy\Immuno:**
Activity Change	Eye Discharge	Cold Intolerance	Environmental Allergies
Appetite Change	Eye Itching	Heat Intolerance	Food Allergies
Chills	Eye Pain	Polydispia (Excessive Thirst)	Immunocompromised
Diaphoresis (Profuse Sweating)	Eye Redness	Polyphagia (Excessive Appetite)	
Fatigue	Light Sensitivity (Photophobia)	Polyuria (Frequent Urination)	**Neurological:**
Fever	Visual Disturbance		Dizziness
Unexpected Weight Change		**GU:**	Facial Asymmetry
	Respiratory:	Difficulty urinating	Headaches
Head Ear Nose Throat:	Apnea	Dysuria (Painful Urination)	Light Headedness
Congestion	Chest Tightness	Enuresis (Bedwetting)	Numbness
Dental Problem	Choking	Flank Pain (Upper Abdomen Pain)	Seizures
Drooling	Cough	Frequency	Speech Difficulty
Ear Discharge	Shortness of Breath	Genital Sore	Syncope
Ear Pain	Stridor (Noisy Breathing)	Hematuria (Blood in Urine)	Tremors
Facial Swelling	Wheezing	Penile Discharge	Weakness
Hearing Loss		Penile Swelling	
Mouth Sores	**Cardiovascular:**	Scrotal Swelling	**Hematologic:**
Nosebleeds	Chest Pain	Testicular Pain	Adenopathy
Postnasal Drip	Leg Swelling	Urgency	Bruises or Bleeds Easily
Rhinorrhea (Runny Nose)	Palpitations	Urine Decreased	
Sinus Pressure			**Psychiatric:**
Sneezing	**GI:**	**Muscle/Skeletal:**	Agitation
Sore Throat	Abdominal Distention (Abdominal Swelling)	Athralgias	Behavior Problem
Tinnitus	Anal Bleeding	Back pain	Confusion
Trouble Swallowing	Blood in Stool	Gait problem	Decreased Concentration
Voice Change	Constipation	Joint swelling	Dysphoric Mood (Depression)
	Diarrhea	Myalgias (Muscle Aches)	Hallucinations
	Nausea	Neck Pain	Hyperactive
	Rectal Pain	Neck Stiffness	Nervous\Anxious
	Vomiting		Self-Injury
		Skin:	Sleep Disturbance
		Color Change	Suicidal Ideas
		Pallor	
		Rash	
		Wound	

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Relationship:	Status: Deceased/Alive	Healthy	Other	Unknown	Heart Disease	Diabetes	High BP	Stroke	High Cholesterol	Breast Cancer	Colon Cancer	Lung Cancer	Melanoma	Ovarian Cancer	Cancer	Osteoporosis	Asthma	Kidney Disease	Thyroid Disease	Liver Disease	Respiratory	Depression	Anemia
Father																							
Mother																							
Sister																							
Brother																							
MGM																							
MGF																							
PGM																							
PGF																							
Daughter																							
Son																							
Other:																							

Tobacco Use:

***Circle all that apply*: Cig. Pipes Chewing Tob. Cigars**

Smoker:	Yes	No
Current Smoker	Packs Per Day: How Many Years:	
Past Smoker	Date Quit: Packs Per Day:	
Smokeless Tobacco	How Many Years:	

Alcohol Use:

Drinks/Week

_____ Glasses of wine
_____ Cans of beer
_____ Shots of liquor
_____ Drinks containing 0.5 oz of alcohol

Language: _____
Ethnicity: _____
Race: _____

Current Physician:_____ Location:_____
Date of last medical exam:_____ Blood Work:_____
Last known EKG:_____ Chest X-Ray:_____
Last known eye exam:_____

If you needed a blood transfusion to save your life, would you accept one? YES NO

To my knowledge, the above stated medical history is true and factual

_____ _____
Patient/guardian date Reviewing Physician date