CIRILLO CENTER
PLASTIC SURGERY

Plastic Surgery
CIRILLO INSTITUTE

Medical History Form

Patient Name: _____ **DOB**: _____/_____/_____

Who Referred You? _____

Primary Care Physician: _____ **Phone**: _____

Note: If you have already used our online Patient Portal to complete pp. 1-2, please skip directly to p. 3.

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation (irregular heartbeat)
Bleeding/Clotting Disorder
BPH (benign prostatic hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (chronic obstructive pulmonary disease)
Coronary Artery Disease/Heart Attack
Depression
Defibrillator
Diabetes
End Stage Renal Disease
GERD (gastroesophageal reflux disease)
Heart Failure
Hearing Loss
Hepatitis
History of blood clot, pulmonary embolism
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Inflammatory Bowel Disease (Crohn's, Colitis)
Leukemia
Lung Cancer
Lymphoma
Osteoarthritis
Pacemaker
Prostate Cancer
Radiation Treatment
Recurrent Miscarriage
Rheumatoid Arthritis
Seizures
Skin Cancer
Sleep Apnea
Stroke
Valve Replacement
None

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD (inflammatory bowel disease)
Gallbladder Removed
Coronary Artery Bypass
PTCA (Coronary Angioplasty)
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Kidney Biopsy
Kidney Removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (transurethral resection of prostate)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

None

Other _____

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Plastic Surgery History:

_____
_____
_____
_____

Medications: (Please enter all current medications, or attach a list)

_____
_____
_____
_____
_____

Preferred Pharmacy: _____ **Phone:** _____

Pharmacy Address: _____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Tobacco Smoking:

- Never smoked
- Quit: former smoker
- Smoke less than daily
- Smoke daily

Do you drink alcohol and how often? ____ None ____ Less than 1 drink per day
____ 1-2 drinks per day ____ 3 or more drinks per day

Please circle Yes or No.

Do you use Drugs?	Yes	No	Other____
Are you pregnant or nursing?	Yes	No	Other____
Do you have a living will?	Yes	No	Other____
If Yes, who is your Healthcare Proxy?	_____		
Did you receive a flu shot this year?	Yes	No	Other____
Did you receive a pneumonia vaccine?	Yes	No	Other____

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Review of Systems: Are you currently experiencing any Symptoms? Please circle Yes or No.

• **Problems with bleeding**	**Yes**	**No**
• **Problems with healing**	**Yes**	**No**
• **Problems with scarring**	**Yes**	**No**
• **Headache**	**Yes**	**No**
• **Chest pain**	**Yes**	**No**
• **Cough**	**Yes**	**No**
• **Shortness of breath**	**Yes**	**No**
• **Thyroid problems**	**Yes**	**No**
• **Nausea**	**Yes**	**No**
• **Vomiting**	**Yes**	**No**
• **Diarrhea**	**Yes**	**No**
• **Constipation**	**Yes**	**No**
• **Chronic pain (if yes, where)?**	**Yes**	**No**
• **Recent illness**	**Yes**	**No**
• **Problems with bleeding**	**Yes**	**No**
• **Problems with healing**	**Yes**	**No**
• **Immunosuppression**	**Yes**	**No**
• **GI upset with antibiotics**	**Yes**	**No**
• **Thyroid problems**	**Yes**	**No**

Other Symptoms: _____
_____
_____
_____
_____

Alerts: Are you currently experiencing any of the following? Please circle Yes or No.

• **History of melanoma**	**Yes**	**No**
• **Allergy to adhesive**	**Yes**	**No**
• **Allergy to latex**	**Yes**	**No**
• **Allergy to lidocaine**	**Yes**	**No**
• **Allergy to topical antibiotic ointments**	**Yes**	**No**
• **Artificial heart valve**	**Yes**	**No**
• **Artificial joints within past 2 years**	**Yes**	**No**
• **Blood thinners**	**Yes**	**No**
• **Defibrillator**	**Yes**	**No**
• **Hepatitis C**	**Yes**	**No**
• **HIV / AIDs**	**Yes**	**No**
• **MRSA** (methicillin resistant staph aureus**)**	**Yes**	**No**
• **Pacemaker**	**Yes**	**No**
• **Pregnancy or planning a pregnancy**	**Yes**	**No**
• **Premedication prior to procedures**	**Yes**	**No**
• **Rapid heartbeat with epinephrine**	**Yes**	**No**

Other Alerts: _____