CIRILLO CENTER
PLASTIC SURGERY

Medical History

Please complete front & back - 4 pages.

Plastic Surgery
CIRILLO INSTITUTE

Date ___/____/____

Patient Name _____ **Patient Date of Birth** _____/_____/_____

Who Referred You? _____

Primary Care Physician _____ **Phone** _____

Height _____ **Weight** _____

Note: If you have already used our online Patient Portal, please start on page 3 at Social History.

Past Medical History *(Please circle all that apply)*

Adrenal Insufficiency
Anemia
Anxiety
Arthritis
Artificial Joints
Asthma
Atrial Fibrillation
Autoimmune Disease
Bipolar Disorder
Bleeding/Clotting Disorder
Blood Clot
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Defibrillator
Depression
Diabetes (Type I, Type II)
Dialysis
Drug Abuse
DVT
End Stage Renal Disease
GERD
Hearing Loss
Heart Attack
Heart Failure
Hepatitis
HIV/AIDS
Hypercholesterolemia
Hypertension
Hyperthyroidism
Hypothyroidism
Inflammatory Bowel Disease (Crohn's, Colitis)
Kidney Disease
Leukemia
Lung Cancer
Lupus
Lymphoma
Neuromuscular Disorder
Pacemaker
Paralysis
Prostate Cancer
Pulmonary Embolism
Radiation Treatment
Rheumatoid Arthritis
Seizures
Sleep Apnea
Stroke
Valve Heart Disease
Vision Loss

Other_____

Skin Disease History *(Please circle all that apply)*

Atypical Moles
Basal Cell Carcinoma
Keloid
Hypertrophic Scarring
Melanoma
Squamous Cell Carcinoma

Other_____

Bryn Mawr Office
919 Conestoga Road
Building Two, Suite 105
Bryn Mawr, PA 19010

Newtown Square Office
3855 West Chester Pike
Suite 325
Newtown Square, PA 19073

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Prior Surgical History *(Please circle all that apply)*

Abdominal Laparoscopy
Abdominal Laparotomy
Appendix Removed
Biological Valve Replacement
Bladder Removed
Brain Surgery
Breast Biopsy (Right, Left, Bilateral)
Colectomy
Colostomy
C-section
Coronary Artery Bypass
Coronary Angioplasty
Gallbladder Removed
Gastrectomy
Heart Transplant
Hepatectomy
Hysterectomy
Joint Replacement, Hip (Right, Left)
Joint Replacement, Knee (Right, Left)
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Liver Transplant
Lumpectomy (Right, Left)
Lung Removal
Mastectomy (Right, Left, Bilateral)
Mechanical Valve Replacement
Ovaries Removed
Pancreatectomy
Pneumothorax
Prostate Biopsy
Prostate Removed
Rectal Surgery
Severe Reaction to Anesthesia
Small Bowel Resection
Spine Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Tubal Ligation
TURP (Transurethral Resection of Prostate)

Other_____

Plastic Surgery History *(Please circle all that apply)*

Abdominal Wall Reconstruction
Abdominoplasty
Blepharoplasty (Upper, Lower)
Brachioplasty
Breast Augmentation
Breast Lift
Breast Reconstruction
Breast Reduction
Brow Lift
Cleft Repair
Ear Reconstruction
Earlobe Repair
Face Lift
Facial Fracture Repair
Flap Reconstruction
Hair Restoration
Hand Surgery
Implant Removal
Laser Resurfacing
Liposuction
Lower Body Lift
Orthopedic Hardware Coverage
Otoplasty
Rhinoplasty
Scar Revision
Septoplasty
Skin Graft
Thigh Lift
Upper Body Lift
Wound Reconstruction

Other_____

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Date ___/____/____

Patient Name _____ **Patient Date of Birth** ____/____/____

Medications & Dosage *(please enter all current medications or attach a list)*

_____
_____
_____
_____
_____

Preferred Pharmacy _____ **Phone** _____

Pharmacy Address _____
_____
_____

Allergies & Reaction *(Please enter all allergies)*

_____
_____
_____
_____
_____

Social History

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

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 COVID-19 shot this year?	Yes	No	Other____
Did you receive a flu shot this year?	Yes	No	Other____
Did you receive a pneumonia vaccine?	Yes	No	Other____
Did you receive a shingles 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**
• **Immunosuppression**	**Yes**	**No**

Other Symptoms

_____
_____
_____
_____

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

• **History of fainting / vasovagal episode**	**Yes**	**No**
• **History of melanoma (if yes, where)?**	**Yes**	**No**
• **Family history of melanoma (if yes, who)?**	**Yes**	**No**
• **History of breast cancer**	**Yes**	**No**
• **Family history of breast cancer (if yes, who)?**	**Yes**	**No**
• **Allergy to adhesive**	**Yes**	**No**
• **Allergy to latex**	**Yes**	**No**
• **Allergy to lidocaine**	**Yes**	**No**
• **Allergy to shellfish/Iodine**	**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**