

  
NORTH CAROLINA  
*plastic surgery*  
CENTER, P.A.  
MEDICAL HISTORY (Submit Below)

PATIENT'S NAME: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_ DATE OF LAST PHYSICAL: \_\_\_\_\_

WHAT ARE YOU BEING SEEN FOR TODAY? \_\_\_\_\_

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK THOSE THAT APPLY)

- |  |   |
|--|---|
| <input type="checkbox"/> HEART PROBLEMS                          | <input type="checkbox"/> ALLERGIES TO ANESTHETICS       |
| <input type="checkbox"/> HIGH BLOOD PRESSURE                     | <input type="checkbox"/> ALLERGIES TO MEDICINE OR DRUGS |
| <input type="checkbox"/> LOW BLOOD PRESSURE                      | <input type="checkbox"/> GENERAL ALLERGIES              |
| <input type="checkbox"/> CIRCULATORY PROBLEMS                    | <input type="checkbox"/> ARTHRITIS                      |
| <input type="checkbox"/> NERVOUS PROBLEMS                        | <input type="checkbox"/> RHEUMATIC FEVER                |
| <input type="checkbox"/> RADIATION TREATMENT                     | <input type="checkbox"/> SINUS PROBLEMS                 |
| <input type="checkbox"/> ARTIFICIAL HEART VALVES<br>OR JOINTS    | <input type="checkbox"/> "AIDS" OR EXPOSURE TO AIDS     |
| <input type="checkbox"/> LUNG/BREATHING PROBLEMS                 | <input type="checkbox"/> STROKE                         |
| <input type="checkbox"/> DIABETES                                | <input type="checkbox"/> VENEREAL DISEASE               |
| <input type="checkbox"/> EPILEPSY                                | <input type="checkbox"/> CHEMICAL DEPENDENCY            |
| <input type="checkbox"/> HEPATITIS, JAUNDICE OR<br>LIVER DISEASE | <input type="checkbox"/> BLEEDING DISORDER              |
|  | <input type="checkbox"/> PSYCHIATRIC CARE               |

PLEASE EXPLAIN ANY POSITIVE RESPONSES: \_\_\_\_\_

HAVE YOU HAD AN ADVERSE REACTION TO ANY MEDICATION? \_\_\_\_\_

HAVE YOU EVER HAD TUBERCULOSIS OR EVER BEEN EXPOSED TO TUBERCULOSIS? \_\_\_\_\_

ARE YOU TAKING ANY MEDICATION AT THIS TIME? \_\_\_\_\_ IF SO, WHAT TYPE? \_\_\_\_\_

DO YOU TAKE ASPIRIN OR ASPIRIN CONTAINING MEDICINE, (BUFFERIN, EXCEDRIN, ALKA-SELTZER)? \_\_\_\_\_ IF SO, WHAT TYPE? \_\_\_\_\_

DO YOU USE TOBACCO PRODUCTS? \_\_\_\_\_ IF SO, WHAT TYPE? \_\_\_\_\_

ARE YOU UNDER THE CARE OF A PHYSICIAN? \_\_\_\_\_ IF YES, FOR WHAT CONDITIONS? \_\_\_\_\_

(WOMEN) DO YOU SUSPECT THAT YOU ARE PREGNANT? \_\_\_\_\_ YES \_\_\_\_\_ NO; ARE YOU NURSING? \_\_\_\_\_ YES \_\_\_\_\_ NO

LIST ANY PREVIOUS SURGERIES \_\_\_\_\_

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR MEDICAL HISTORY? \_\_\_\_\_

THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND IS FOR USE IN MY TREATMENT. I WILL NOT HOLD MY DOCTOR OR HIS STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_