

LOWCOUNTRY PLASTIC SURGERY CENTER, LLC

HISTORY INTAKE FORM

Please answer all of the questions as accurately as possible. If you do not understand the question, please ask for assistance.

Name: _____ Birthdate: _____ Age: _____
Primary Care Doctor: _____ Referring Doctor: _____
Reason for Consultation: _____
Last Physical Exam _____
Drug Allergies: _____

Previous Surgeries and Major Illnesses with Dates

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

Medications (Including Non-Prescription Drugs, Vitamins And Herbals)

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

PAST MEDICAL HISTORY

Have you ever had any of the following?

Glaucoma.....no	yes	Asthma.....no	yes	Stomach Ulcer.....no	yes
Anemia.....no	yes	Tuberculosis.....no	yes	Kidney Disease.....no	yes
Diabetes.....no	yes	Heart disease.....no	yes	Hepatitis.....no	yes
Cancer.....no	yes	Rheumatic Fever.....no	yes	Stroke.....no	yes
AIDS or HIV+.....no	yes	Mitral Valve Prolapse.....no	yes	Arthritis.....no	yes
Thyroid Disease.....no	yes	High Blood Pressure.....no	yes	Psychiatric Treatment.....no	yes

REVIEW OF SYSTEMS

Do you have now or have you had within the past year any of the following?

Fatigue.....yes	Nosebleeds.....yes
Fever.....yes	Vision changes.....yes
Weight gain.....yes	Dry eyes.....yes
Weight loss.....yes	Watering eyes.....yes
Diabetes.....yes	Glasses.....yes
Easy bleeding.....yes	Contact lenses.....yes
Easy bruising.....yes	Neck pain.....yes
Swollen lymph nodes.....yes	Chronic cough.....yes
Recent infection.....yes	Wheezing.....yes

_____ Check here if none of the following.

Chest pain.....yes	Muscle pain.....yes
Rapid heartbeat.....yes	Swollen feet/ankles.....yes
Abdominal pain.....yes	Skin rash.....yes
Nausea/Vomiting.....yes	Skin lesion (mole).....yes
Diarrhea.....yes	Dizziness.....yes
Constipation.....yes	Numbness.....yes
Hernia.....yes	Seizures.....yes
Joint pain.....yes	Anxiety.....yes
Back pain.....yes	Depression.....yes

SOCIAL HISTORY

Smoking (type and amount per day): _____ Alcohol (type and amount per day): _____
If former, smoker date quit: _____ Height: _____ Weight: _____

FAMILY HISTORY

Has any blood relative had any of the following?

Breast Cancer.....no	yes	Stroke.....no	yes	Diabetes.....no	yes
Melanoma.....no	yes	High Blood Pressure.....no	yes	Kidney Disease.....no	yes
Cancer (list type below).....no	yes	Heart Disease.....no	yes	Depression.....no	yes
Other medical problems _____					

FOR WOMEN ONLY

Age period began _____	Number of pregnancies _____	Nipple discharge.....yes
Date of last mammogram _____	Did you breast feed?.....yes	Breast mass.....yes
Do you do regular breast self-examinations?.....yes		Breast pain.....yes

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____

Signature of patient or parent if minor

_____ Date