Patient History

THE GRAIVIER CENTER
PLASTIC SURGERY • MEDSPA

Patient's Name: ______________________________

Reason for consultation: ______________________________

All Family Physicians and Specialists, if applicable: ______________________ City & State: ______________________

Allergies: medications, food, latex or other (please list all, including but not limited to, seasonal allergies, hay fever, pet dander, dairy, red dyes, etc.):

____

How do you react to the allergies (example: hives, swelling, difficulty breathing etc.): ______________________________

____

Have you ever smoked? ❑ yes ❑ no

Do you currently smoke? ❑ yes ❑ no Packs / day: ________ Number of years ________

Do you drink alcohol, beer and/or wine? ❑ yes ❑ no Amount / week: ____________

History of alcohol or substance abuse? ❑ yes ❑ no

Have you ever received any treatment or counseling or have you ever been hospitalized for alcohol or substance abuse? ❑ yes ❑ no

Are you planning to get pregnant? ❑ yes ❑ no Are you currently pregnant or breast feeding? ❑ yes ❑ no

Pregnancies: ____________ C-sections: ____________

Please mark any of the following medications if you take them daily or have taken them during the last two weeks:

- ❑ Aspirin
- ❑ Alkaseltzer
- ❑ Motrin
- ❑ Ibuprofen
- ❑ Bufferin
- ❑ Arthritis Medication
- ❑ Blood Thinner
- ❑ PeptoBismol
- ❑ Cortisone
- ❑ Prednisone / Steroids
- ❑ Medrol
- ❑ Insulin
- ❑ Estrogen
- ❑ Progesterone
- ❑ Birth Control Pill
- ❑ Antibiotics
- ❑ Asthma Medication
- ❑ Chemotherapy
- ❑ Heart Medication
- ❑ Vitamin E
- ❑ Vitamin A
- ❑ Vitamin K
- ❑ Hgh /antiaging drugs
- ❑ Over the counter medications: ______________
  (*Please include any aspirin or aspirin containing medications.*)
- ❑ Other: ______________________________
  ____

Have you had any problems with the following organs or diseases?

- ❑ Heart
- ❑ High Blood Pressure
- ❑ Excessive bleeding in surgery
- ❑ Easy bruising
- ❑ Lungs (breathing)
- ❑ Thyroid
- ❑ Kidneys
- ❑ Diabetes (High Blood Sugar)
- ❑ Urinary Bladder
- ❑ Liver
- ❑ Gallbladder
- ❑ Asthma
- ❑ Anxiety
- ❑ Cancer (any kind)
- ❑ Hepatitis
- ❑ Ulcers
- ❑ Arthritis
- ❑ Heavy Menses
- ❑ Stomach
- ❑ Brain
- ❑ Bleeding gums
- ❑ Tuberculosis
- ❑ HIV
- ❑ DVT (blood clots)

Please list all medications, prescription and nonprescription, taken on a daily basis:

____

Please list any previous serious illnesses and dates:

Illness: ______________________________ Date: ____________

Illness: ______________________________ Date: ____________

Please list previous surgeries or procedures (inpatient, outpatient or office) and dates:

Surgery: ______________________________ Date: ____________

Surgery: ______________________________ Date: ____________

Surgery: ______________________________ Date: ____________

Scarring: ____________ Location: ____________ Hypertrophic / Keloid Scar: ____________

Please list any injuries and dates:

Injuries: ______________________________ Date: ____________

Injuries: ______________________________ Date: ____________

Please list any history of psychological disorders (examples: depression, substance abuse, bi-polar, etc. and treatment received):

______________________________ Date: ____________

______________________________ Date: ____________

Have any relatives had:

	Which relative?		*Which relative?*
❑ Diabetes	____________	❑ Asthma	____________
❑ Heart Attack	____________	❑ Cancer	____________
❑ Heart Disease	____________	❑ Stroke	____________
❑ Bleeding Disorder	____________	❑ Breast Cancer	____________

❑ Malignant Hyperthermia (high fevers with anesthesia) ____________

Date of most recent: ❑ Mammogram: ____________ ❑ EKG ____________ ❑ Physical ____________

The above information is accurate and true to the best of my knowledge.

Patient or Guardian Signature: ______________________________ Date: ____________