

Joanna L. Partridge, MD, PC

Cosmetic and Reconstructive Plastic Surgery

PATIENT HISTORY FORM

Name: _____ Date: _____

DOB: _____ Height: _____ Weight: _____

Gender: Male / Female

Pregnancy: Yes / No

Last Mammogram: ____/____/____

Immunizations up to date? Yes /No Last Tetanus: _____(year)

Allergies:

Reactions:

Surgical History: (list ALL operations and year performed)

Operation:

Year Performed:

Current Medications

Name / Strength	Frequency	Purpose	Effectiveness

Reason for Seeing Doctor: (check all that apply)

Reconstructive Surgery:

Trauma _____
Hand Surgery _____
Skin Cancer _____

Broken Bone _____
Hernia _____
Breast Reconstuction _____

Other Surgery _____ (specify)

Cosmetic Surgery:

Alloderm _____
Breast Lift _____
Collagen _____
Dermabrasion _____
Facelift _____
Gynecomastica _____
Liposuction _____
Laser Surgery _____
Vein Removal _____

Armlift (brachioplasty) _____
Breast Reduction _____
Chemical Peel _____
Ear Pinning _____
Fat Transfer _____
Hair Removal _____
Liposculpture _____
Tummy Tuck _____
Scar Revision _____

Breast Augmentation _____
Botox _____
Chin Implant _____
Eyelid Surgery _____
Facial Resurfacing _____
Hair Transplant _____
Lower Body Lift _____
Thigh Lift _____
Other _____ (specify)

Name: _____ DOB: ____/____/____

SOCIAL HISTORY: Please indicate your tobacco, alcohol , caffeine and dietary habits.

Smoking History

_____ never smoked
_____ packs per day for _____ years
_____ stopped _____ year(s) ago

Caffeine History

_____ never consumed
_____ drinks per day
_____ stopped _____ year(s) ago

Alcohol History

_____ never consumed
_____ drinks per day/week
_____ stopped _____ year(s) ago

Dietary History

_____ number of meals per day
_____ food restrictions: _____

Anabolic Steroid or Growth Hormone Usage: Yes / No **When:** _____

MEDICAL HISTORY: Have you or any blood relative had (mark all that apply)

	self	relative
hypertention	_____	_____
asthma	_____	_____
cancer	_____	_____
type of cancer	_____	_____
depression	_____	_____
lung disease	_____	_____
diabetes	_____	_____

	self	relative
heart disease	_____	_____
stroke	_____	_____
kidney disease	_____	_____
mental illness	_____	_____
substance abuse	_____	_____
other	_____	_____

MEDICAL PROBLEMS: Have you experienced, or do you have: (circle Y or N)

known kidney problems?	Y	N	sores on legs or feet?	Y	N
frequent urinary infections?	Y	N	known blood clot problems?	Y	N
difficulty with urination?	Y	N	leg pain or swelling?	Y	N
frequent urination at night?	Y	N	unusual bleeding or bruising?	Y	N
known liver problems/hepatitis?	Y	N	anemia?	Y	N
trouble eating certain foods?	Y	N	thyroid problems?	Y	N
nausea or vomiting?	Y	N	known hormone problems?	Y	N
constipation or diarrhea?	Y	N	arthritis or joint problems?	Y	N
bloody or black bowel movements?	Y	N	muscle cramps or weakness?	Y	N
abdominal pain or cramps?	Y	N	memory problems?	Y	N
frequent heartburn/indigestion?	Y	N	dizziness?	Y	N
stomach ulcers in the past?	Y	N	hearing or visual problems?	Y	N
shortness of breath?	Y	N	frequent headaches?	Y	N
coughing up of phlegm or blood?	Y	N	rash or hives?	Y	N
chest pain or tightness?	Y	N	change in appetite/taste?	Y	N
fainting spells or passing out?	Y	N	walking/balance problems?	Y	N
thumping or racing heart?	Y	N	other problems?	Y	N

OTHER INFORMATION/COMMENTS:

Patient signature: _____ Date: _____

I have personally reviewed and confirmed this information with the patient _____/____/____