RENUE PLASTIC SURGERY

Bill Mitchell, MD
Steve Barr, MD
Bradley Easterlin, MD

Name_____ DOB_____ Date_____

Reason For Today's Visit: _____ Lab Preference_____

Primary Care Physician: _____
Name *Address, if you know it* *Phone #*

Smoker: Current/Former/Never If yes, how many per day? _____ Age Started___ Age Stopped___ Height: _____
Alcohol: Yes No If yes, how much? _____ Weight: _____

Are you currently pregnant? Yes No If yes, how many weeks? _____

PHARMACY NAME: _____Phone number_____

LIST ALL MEDICATIONS YOU NOW TAKE INCLUDING DOSAGE, INCLUDING NON-PRESCRIPTION (OVER-THE-COUNTER) MEDICATIONS

MEDICATION	**DOSE**	**HOW OFTEN TAKEN**	**REASON FOR TAKING**

LIST ANY ALLERGIES YOU HAVE: Medications, Foods, Items (pollen, tape, soaps, latex, iodine, peanuts, eggs etc)

_____

LIST OPERATIONS/SURGERIES YEAR

_____ _____

_____ _____

_____ _____

DO YOU HAVE PAST OR CURRENT HISTORY OF THE FOLLOWING (PLEASE CHECK ALL THAT APPLY)

____Anesthesia Reactions (type_____)
____Arthritis(Type_____)
____Asthma
____Bleeding Disorder(Type_____)
____Cancer(Type_ ____)
____COPD
____Diabetes____ on insulin
____Dialysis
____GI(ulcer, Hiatal Hernia, Reflux)
____Hearing Aids/ Use cane or walker
____Heart Attack
____Heart Disease
____Heart Murmur
____Hepatitis(Type_____)
____HIV(AIDS)
____Kidney Disease
____Malignant Hyperthermia
____Mental Health Conditions
____Pressure sore(non-healing)
____Rectal Bleeding
____Shortness of Breath
____Sleep Apnea/ CPAP machine
____Steroidal Medications
____Stroke
____Substance abuse/addition
____Thyroid Disorder
____Tuberculosis

If you have checked ANY of the above, please explain each item and the date treated:

_____

Do you have to take oral antibiotics prior to procedures: Yes No If yes, what is the reason?_____

Do you have any family history of the following? (Please check all that apply and the family member affected)

____Asthma/Lung Disorder____
____Cancer (type_____)____
____Diabetes_____
____GI (Ulcers, Hiatal hernia, Reflux)_____
____Heart Disease_____
____Hepatitis(type_____)_____
____High Blood Pressure_____
____Kidney Disease_____
____ Malignant Hyperthermia_____
____Stroke____
____Thyroid Disorder_____
____Tuberculosis_____

My signature below certifies that the information is correct to the best of my knowledge.

_____ Reviewed with Patient_____
Patient Signature Date_____