

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: _____

Is your condition related to: _____ Employment _____ Auto Accident _____ Other Accident _____ Cosmetic

Previous Surgeries and Major Illnesses with Dates

Medications (Including Non-Prescription Drugs, Vitamins and Herbs)

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

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?

_____ Check here if none of the following.

Fatigue..... yes	Nosebleeds..... yes	Chest pain.....yes	Muscle pain.....yes
Fever..... yes	Vision changes..... yes	Rapid heartbeat.....yes	Swollen feet/ankles.....yes
Weight gain..... yes	Dry eyes..... yes	Abdominal pain.....yes	Skin rash.....yes
Weight loss..... yes	Watering eyes..... yes	Nausea/Vomiting.....yes	Skin lesion (mole).....yes
Diabetes..... yes	Glasses..... yes	Diarrhea.....yes	Dizziness.....yes
Easy bleeding..... yes	Contact lenses..... yes	Constipation.....yes	Numbness.....yes
Easy bruising..... yes	Neck pain..... yes	Hernia.....yes	Seizures.....yes
Swollen lymph nodes..... yes	Chronic cough..... yes	Joint pain.....yes	Anxiety.....yes
Recent infection..... yes	Wheezing..... 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