Murphy PLASTIC SURGERY
DEFINING EXCELLENCE

Patient Medical History

Name: _____ **Date of Birth:** _____

Please tell us what procedures you are interested in:

_____

Height: _____ **Weight:** _____

Do you Smoke? No Yes, How many packs per day? _____

How much alcohol do you drink?

None Occasional Social Daily More than 2 drinks a day more than 7 drinks a day

Do you have any allergies? Please list the medication or allergen and type of reaction:

1. _____
2. _____
3. _____
4. _____
5. _____

Are you currently taking any vitamins, minerals or supplements?

No Yes, (please list type and dosage)

1. _____
2. _____
3. _____
4. _____
5. _____

Are you currently taking any medications? No Yes, (please list type, dosage and frequency)

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have a history of any of the following bleeding problems?

Easy bleeding Von Willebrands Hemophilia Excessive clotting
History of DVT History of PE Anemia Anticoagulation
Other _____

Do you have problems with chronic dry eye which requires eye drops? No Yes
Have you had Lasik surgery within the last six months? No Yes
Do you wear contact lenses? No Yes

Have you had a history of any of the following?
General History:

Recent weight gain Recent weight loss Poor nutrition Chronic fatigue
Other _____

Psychiatric/ Neurologic History:
Seizures Depression Anxiety Fibromyalgia Other _____
Ear/Nose/Throat History:
Blepharospasm Hearing loss Wear glasses Vision loss Snoring/Apnea other_____
Cardiac History:
HTN Hyper cholesterol CHF Myocardial infarction Arrhythmias Pacemaker
Mitral Valve Prolapse Other _____
Pulmonary History:
Asthma PTX COPD Emphysema Other _____ ☐ Sleep Apnea ☐ Use CPAP
Hepatic History:
Hepatitis A Hepatitis B Hepatitis C Cirrhosis Jaundice
Gallstones Other _____
Renal History:
Kidney stones Renal Insufficiency Renal failure Pyelonephritis
Urinary tract infection Other _____
Gastrointestinal History:
Bleeding Ulcers Constipation Diverticulosis GERD Non-Bleeding Ulcers Hemorrhoids
Irritable bowel Other _____
Pregnancy history:
Vaginal Delivery, How Many? _____ C-Section Delivery, How Many? _____
Recurrent UTI Incontinence Urethral Stricture Other _____
Extremity History:
Varicose veins Chronic Edema Ulcers Difficulty Walking Other _____
Breast History:
Breast Mass, Left or Right Nipple Discharge, Left or Right History of Breast Feeding
Intertriginous Rashes Other _____
Endocrine History:
Diabetes, diet controlled Diabetes, oral medication
Diabetes, insulin dependent Hyperthyroid Hypothyroid Other _____
Infectious Disease History:
HIV Oral herpes Genital Herpes Genital warts Other _____
Anesthesia History:
Difficult Intubation Difficult Extubation Post-Op Nausea/Vomiting Malignant Hypothermia Other
Cancer History:
Skin Breast Lung Liver Colon Other _____
Other Health History Not Mentioned Above: _____

Does anyone in your family have a history of the following?
Abnormal bleeding Anesthesia Problems Autoimmune Disorders Cancer Diabetes Heart Disease
Kidney Disease Liver Disease Lung Disease Endocrine Disease Other _____

Past Surgical History:
Cosmetic surgery type and date: _____
_____
_____

Other surgery type and date: _____
_____
_____

_____ _____
Patient's Signature Date