Menard Plastic Surgery
MEDICAL HISTORY FORM

_____ _____ _____ _____
LAST NAME FIRST NAME MIDDLE/MAIDEN DATE

_____ _____ _____ _____ _____ _____ _____
DOB AGE Marital Status # of Children Height Weight Occupation

PLEASE CIRCLE Y (YES) N (NO)

N Y Are you a Jehovah's Witness If Yes, PLEASE Notify Your Nurse
N Y Do you have an Advanced Directive? Such as A Living Will or Durable Power of Attorney
N Y Are you Pregnant?
N Y Do you Exercise How Often? _____
N Y Do you Smoke Packs /day _____How many Years? _____
N Y Do you Drink? How Often? _____
N Y Have you fallen in the past year?
N Y Is this visit related to an injury? Date of onset _____
N Y Are you Allergic to Latex?
Are you RIGHT handed or LEFT handed (Please circle one)
Dates of Your Last Shots: Tetanus _____ Flu_____ Pneumonia_____
Have you been HOSPITALIZED in the past year?
__NO __YES (Please explain)

N Y Medication Allergies? Please Explain: _____
_____
_____
_____

PATIENT'S CURRENT MEDICATIONS AND DOSAGE:

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Family Medical History: Has a Family Member had any of the following health conditions?
Please indicate which family member using F (*Father*) M (*Mother*) S (*Sibling*) GF (*Grandfather*) GM (*Grandmother*)

Stroke_____ Diabetes _____
Heart Disease_____ High Blood Pressure_____
Cancer _____
Type of Cancer_____
Problems with Anesthesia _____
Bleeding Disorder_____Other_____

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE