COLUMBIA PLASTIC SURGERY
HISTORY AND PHYSICAL

PATIENT'S NAME: ____ **AGE:** _______________

HEIGHT: _____________ **WEIGHT:** _______________ **NUMBER OF CHILDREN:** ________________

Part 1 HISTORY **DATE:** ___________________________________

The following questions are to be filled out by the patient. Check box **YES** or **NO**. Any positive response will be discussed with you by your doctor.

LUNGS	YES	NO
Born with any lung disease	☐	☐
Cough or cold (at present)	☐	☐
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Smoke _____ packs of cigarettes per day for the past _____ years	☐	☐

HEART	YES	NO
Born with any heart disease	☐	☐
Heart murmur	☐	☐
High blood pressure	☐	☐
Skipped heart beats	☐	☐
Chest pain	☐	☐
Hardening of the arteries	☐	☐
Heart failure	☐	☐
Heart attack	☐	☐
Rheumatic fever	☐	☐

BLOOD	YES	NO
Do you bruise or bleed easily	☐	☐
Abnormal bleeding (of any kind) in family	☐	☐
Sickle cell trait/disease	☐	☐
Other blood disease	☐	☐
Prolonged bleeding with tooth extraction	☐	☐

LIVER	YES	NO
Drink alcoholic beverages	☐	☐
Hepatitis	☐	☐
Jaundice	☐	☐
Other liver disease	☐	☐

KIDNEY	YES	NO
Born with any kidney disease	☐	☐
Kidney infections/disease	☐	☐
Kidney stones	☐	☐

IN ORDER TO HAVE SURGERY, YOU MUST COMPLETE BOTH HISTORY AND PHYSICAL PAGES!

NERVOUS SYSTEM	YES	NO
Born with any abnormality	☐	☐
Brain disease	☐	☐
Spinal cord disease	☐	☐
Nerve disease	☐	☐
Epilepsy	☐	☐
Stroke	☐	☐

ENDOCRINE	YES	NO
Diabetes (blood sugar)	☐	☐
Thyroid disorder	☐	☐

EYE	YES	NO
Glaucoma	☐	☐
Contact lenses	☐	☐

STOMACH, BOWEL, GALL BLADDER	YES	NO
Any disease of?	☐	☐

AIRWAY	YES	NO
Problems opening mouth wide	☐	☐
Problems turning head in any direction	☐	☐

REPRODUCTIVE	YES	NO
Female: Are you pregnant?	☐	☐
Planning pregnancy pre-operatively	☐	☐
Breast fed in last 3 months	☐	☐

Date of last mammogram ____________________

MUSCULOSKELETAL	YES	NO
Any injury or damage to:		
Joints	☐	☐
Tendons	☐	☐
Nerves	☐	☐

Do you have any past or present health problems not indicated above? If yes, please describe: ________________________
____
____

Do any diseases run in your family? ____________________
____
____

SURGICAL HISTORY: List previous operations and approximate dates:
____
____
____
____

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	YES	NO
Have you ever had complications after surgery?	☐	☐
Bleeding or blood clot	☐	☐
Infections	☐	☐

Other: ______________________________________
____
____

ANESTHETIC HISTORY

Date of last general anesthetic: ________________

Any problems resulting from any local or general anesthesia ever administered to you?	☐	☐
Nausea and/or vomiting?	☐	☐
Any family members with problems related to anesthesia?	☐	☐

If you answered yes, please explain: ____________
____
____

DRUG ALLERGIES: (List with reaction):
____
____
____

Who is your primary physician?
____

City: ____________________________________

Phone number: ____________________________

LIST *ALL* PRESENT MEDICATIONS (By name and the reason for taking them). Especially important are: Cortisone, hormones or birth control pills, cold medications, aspirin or aspirin containing medications, tranquilizers, sedatives, antidepressants, blood thinners (anticoagulants), heart medications, and water pills (diuretics).
____
____
____
____
____
____
____

Any history of arthritis? _______________________

If so, what type? ____________________________

Please list any arthritis medication: _____________
____

Name of physician treating arthritis:
____

Date:
____