Plastic Surgery Center

5 Livingston Street Asheville NC 28801

Patient Health Disclosure Statement

Please answer all questions **Date:**____________________

Name:___________________________ Age _____ HT _____ WT _____ WT 1 year ago________

Are you under a Doctor's care? Yes No If yes, for what condition:________________________________

Illnesses (List any chronic illness): 1.__________________________ 2.______________________________
3._____________________________ 4.__________________________ 5.______________________________

Operations (List all previous surgery): 1.___________________________2.__________________________________
3._____________________________4._____________________________5.___________________________________
Other: ____

Habits:
Alcohol Never Rarely Daily Have you ever been treated for Alcoholism Yes No
Tobacco Never Rarely Daily Packs per day______ How long?________Cigar/Pipe Yes No

Do you have (circle): Dentures Capped teeth Bridges Chipped teeth Diseased Gums
Contact Lenses Glasses Hearing Aid Other prosthetic devices______________

Important Medical Conditions: Have you ever had or received treatment for any of the following?
(Please Circle)

Hepatitis, jaundice, cirrhosis, or liver disease?	Yes	No	Blood transfusions?	Yes	No
Asthma, TB, Pneumonia, Emphysema, or chest disease?	Yes	No	HIV or AIDS?	Yes	No
Heart attack, angina, palpitations, or irregular heart beats?	Yes	No	Anemia or blood disorder?	Yes	No
Shortness of breath, or fainting spells?	Yes	No	Chronic or recent cough?	Yes	No
Rheumatic fever or congenital heart disease?	Yes	No	Abnormal or excessive bleeding?	Yes	No
High blood pressure or Low blood pressure?	Yes	No	Hives, rashes, or skin diseases?	Yes	No
Kidney failure, kidney or prostate problems?	Yes	No	Alcohol abuse or addictions?	Yes	No
Migraines, headaches or chronic head pain?	Yes	No	Drug abuse or addictions?	Yes	No
Eating disorder, anorexia, or bulimia?	Yes	No	Diabetes, or abnormal "blood sugar"?	Yes	No
Lupus, arthritis, or autoimmune disease?	Yes	No	Thyroid problems?	Yes	No
Psychological or emotional problems?	Yes	No	X-ray treatments or radiation therapy?	Yes	No
Nervous breakdown or personality disorder?	Yes	No	Adverse or unusual reaction to anesthesia?	Yes	No
Phlebitis, blood clots or varicose veins?	Yes	No	Abnormal healing or poor scar formation?	Yes	No
Stroke, seizures, Bell's palsy or neurological problems?	Yes	No	Edema, persistent or unusual swelling?	Yes	No
Shingles, cold sores, fever blisters or oral herpes?	Yes	No	Venereal disease?	Yes	No
Stomach ulcers?	Yes	No	Anxiety or "panic attacks"?	Yes	No
Recent weight gain or loss?	Yes	No	Anaphylaxis?	Yes	No
Sleep Apnea Yes No - If yes, do use use a CPAP?	Yes	No	DVT/blood clots	Yes	No

Gastric Reflux Yes No - If yes, are you on medication? (name)____

Other Medical Conditions (Explain)____

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 Name:____________________

Drugs and Medicines: Have you, within the last 6 months, taken any of the following?
(If yes, please circle)

Cortisone, prednisone, or ACTH?	Yes	No	Anticoagulants or blood thinner?	Yes	No
Diuretics or water pills?	Yes	No	Pain Pills?	Yes	No
Heart medication, Digitalis, Lanoxin?	Yes	No	Homeopathic or herbal medicines?	Yes	No
Blood pressure medication?	Yes	No	Stimulants, appetite suppressants, diet pills?	Yes	No
Nitroglycerin?	Yes	No	Sedatives, tranquilizers, or sleeping pills?	Yes	No
Steroids or body building drugs?	Yes	No	Antidepressants, antipsychotics, or nerve pills?	Yes	No
Headache or migraine medications?	Yes	No	Recreational or illegal drugs?	Yes	No
Seizure medication?	Yes	No	Phen-Phen or Redux?	Yes	No
Antibiotics?	Yes	No	Birth Control Pills?	Yes	No
Insulin, Orinase, or similar drugs?	Yes	No	Asthma Meds, inhalers, etc?	Yes	No

List drugs by name:____

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Other drugs or medications? (List)____

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Medications that cause bleeding: Have you taken any of the following in the last 2 weeks?
(If yes, please circle)

Aspirin or aspirin containing medications:	Yes	No	Vitamin E?(excluding multivitamins)	Yes	No
Ibuprofen (Motrin, Advil, Nuprin) containing medications?	Yes	No	Anti-inflammatories or muscle relaxants?	Yes	No

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Allergies and Sensitivities: Is there any history of skin reaction or other illness following the administration of:
(If yes, please circle)

Penicillin, Sulfa, or other antibiotics?	Yes	No	Tetanus toxoid or serum?	Yes	No
Morphine, Codeine, Demerol or narcotic?	Yes	No	Tincture of Benzoin?	Yes	No
Novocain, Lidocaine, or local anesthetics?	Yes	No	Adhesive tape?	Yes	No
Iodine, Betadine, Chlorhexidine, or PhisoHex?	Yes	No	Latex rubber?	Yes	No
Other drugs or medications? (List):			Dairy products?	Yes	No

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Do you have a family history of bleeding disorders:____________________________________

Date of Last Mammogram:_________________ Do you have a family history of breast cancer:___________________

Pregnancy:

Are you now pregnant?	Yes	No	Are you breast feeding?	Yes	No
Number of pregnancies:____________			Number of children:_________________		
Are you sexually active?	Yes	No	Are you currently using birth control?	Yes	No

I certify that the above is true and correct. I realize that withholding information about my medical history could result in serious injury to me or harm to those involve in my care. I am aware that providing either false or incomplete information about my medical and surgical history may result in the cancellation of my proposed surgical procedure and also result in forfeiture of my surgical fees.

____ ______________________________

Patient Signature Date