Hallmark Plastic Surgery
Health History

Patient Name: ______________________________ **Birth Date:**________

Please answer all of the questions as accurately as possible. If you do not understand the question, please ask for assistance.

Primary Care Doctor:____________________ **Referral Doctor:**______________

Smoking (type & amount per day)______________________________

If former smoker, date quit:______________ Weight________ Height__________

Alcohol (type & amount per day)____

Drug allergies(reaction):____

List previous surgeries or major illnesses and dates:______________

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List any medications and dosage you are taking, *including* non-prescription drugs, vitamins, and herbals____

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Family History:

Has any blood relative ever had the following:

Breast Cancer	...........no	yes	High blood pressure......no	yes	Kidney disease.......... no	yes
Melanoma	..............no	yes	Heart Disease ....no	yes	Depression.............. no	yes
Stroke	...................no	yes	Diabetes....................no	yes		

Past Medical History:

Have you ever had the following:

Heart disease...........no	yes	Cancer....................no	yes	Stomach Ulcer......... no	yes
Arthritis.................no	yes	Glaucoma...............no	yes	Kidney Disease........ no	yes
Rheumatic Fever......no	yes	Asthma................. no	yes	Thyroid Disease...... no	yes
Anemia..................no	yes	AIDS or HIV+..........no	yes	Bleeding tendency..... no	yes
Tuberculosis..........no	yes	Stroke....................no	yes	Mitral Valve Prolapse no	yes
Diabetes................no	yes	Hepatitis.................no	yes	High Blood Pressure...no	yes

Review of Systems:

Do you have now or have you had within the past year:

Weight Change.......no	yes	Swollen feet/ankles.....no	yes	Seizures...................no	yes
Dry eyes.................no	yes	Skin rash..................no	yes	Joint or muscle pain....no	yes
Chronic cough........no	yes	Chronic diarrhea.........no	yes	Swollen lymph nodes...no	yes
Chest pain.............no	yes	Jaundice.................. no	yes	Easy bleeding.............no	yes
Rapid heart beat......no	yes	Depression...............no	yes	Easy bruising..............no	yes

Women only:

Age period began____________ Number of pregnancies______________

Date of last mammogram______________ Did you breast feed? No Yes

Do you do regular breast self-examinations? Breast lump or discharge? No 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