Galardi | Bowen | Rosenblum Plastic Surgery, Inc
PATIENT'S PERSONAL HISTORY

Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in his decisions regarding your care.

Name:____ Date:_____________________________

Age:__________________________ Height:_______________ Weight:__________________________

Referring Physician:__________________ Primary Care Physician:_________________________

Reason for visit:____

How did you hear about us **Physician** **Friend** **Previous Patient** **Internet site**_________________

Do you have or have you had: (circle yes or no. If yes, please explain)

Headaches (frequent)	**NO**	**YES**	**Dizziness**	**NO**	**YES**
Visual Loss	**NO**	**YES**	**Seizures**	**NO**	**YES**
Nosebleeds	**NO**	**YES**	**Swollen Glands**	**NO**	**YES**
Recent Coughing	**NO**	**YES**	**Cold Sores**	**NO**	**YES**
Wheezing	**NO**	**YES**	**COPD**	**NO**	**YES**
Persistent Infections	**NO**	**YES**	**Kidney Disease**	**NO**	**YES**
Liver Disease	**NO**	**YES**	**Hepatitis**	**NO**	**YES**
Emphysema	**NO**	**YES**	**Bruise Easily**	**NO**	**YES**
Short of Breath	**NO**	**YES**	**Pneumonia**	**NO**	**YES**
Tuberculosis	**NO**	**YES**	**Stroke**	**NO**	**YES**
Shingles	**NO**	**YES**	**Heart Attack**	**NO**	**YES**
High Blood Pressure	**NO**	**YES**	**Irregular Heart Beat**	**NO**	**YES**
Rash	**NO**	**YES**	**Swelling Hands/Feet**	**NO**	**YES**
Diabetes	**NO**	**YES**	**Mitral Valve Prolapse**	**NO**	**YES**
Ulcers	**NO**	**YES**	**Hypoglycemia**	**NO**	**YES**
Intestinal/Colon problems	**NO**	**YES**	**Urinary Problems**	**NO**	**YES**
AIDS/Positive HIV test	**NO**	**YES**	**Thyroid Problems**	**NO**	**YES**
Lyme Disease	**NO**	**YES**	**Back Pain**	**NO**	**YES**
Lupus	**NO**	**YES**	**Heart Surgery**	**NO**	**YES**
Sleep Apnea	**NO**	**YES**	**Asthma**	**NO**	**YES**
History of Mental Illness	**NO**	**YES**	**Atrial Fibrillation(AFib)**	**NO**	**YES**
Neck Pain	**NO**	**YES**	**Breast Pain**	**NO**	**YES**
Chest Pain	**NO**	**YES**	**Abdominal Pain**	**NO**	**YES**
Nausea	**NO**	**YES**	**Vomiting**	**NO**	**YES**

Explain all "yes" answers: ____
____
____

Allergies to medications: ____

Current medications you are on: ____________________: ___________________________:_______________
____________________: _________________________ : ___________________________:_______________
____________________: _________________________: ___________________________: _______________
____________________: _________________________: ___________________________: _______________
____________________: _________________________: ___________________________: _______________

Do you take **birth control or hormone replacement** medications including, oral contraceptives, Nuva ring, Mirena, Progesterone or Estrogen hormone patches **NO YES**

If yes, please list the most recent dose and frequency____

Do you take **blood thinning medications** including Aspirin, Baby Aspirin, Aleve, Ibuprofen, Naproxen Xarelto, Plavix, fish oil or flax seed on a regular basis **NO YES**

If yes, please list most recent dose and frequency ____

# of Children: __________ Ages: ___________ C-Section/Vaginal: ___________

Are you currently pregnant **NO YES**

Previous Surgeries or Cosmetic Procedures:

_____________________ Date: ________ _____________________ Date: ________

_____________________ Date: ________ _____________________ Date: ________

_____________________ Date: ________ _____________________ Date: ________

Have you ever received a blood transfusion and/or blood products ____________________________

Problems with:

Anesthesia NO YES
Bleeding NO YES (hemophilia / Von Willebrand Disease)
Blood Clots NO YES (prior DVT / pulmonary embolism / Factor V Leiden)
Scarring NO YES (keloids / hypertrophic scar)

Family Medical History:

Anesthesia NO YES
Bleeding NO YES (hemophilia / Von Willebrand Disease)
Blood Clots NO YES (prior DVT / pulmonary embolism / Factor V Leiden)
Scarring NO YES (keloids / hypertrophic scar)

Other Family medical conditions: ____
Mother: ____
Father: ____

Social History:

Occupation: _____________________ Marital Status: ___________________________

Alcohol use: _____________________ History of drug use/abuse: _________________

Do you smoke **NO YES** If so, how much _________________________

Have you EVER smoked **NO YES** If yes, When did you quit _________________
Other tobacco use:_________________

PLEASE FILL OUT ONLY WHAT PERTAINS TO YOUR VISIT TODAY

Other medical information you feel we should know about: ______________________________

____

____

Here to Discuss a Skin Lesion: **YES** **NO**

How long has the lesion been present ____
Has the lesion:
Grown ________________ Changed Color ____________________
Itched _________________ Been Painful ______________________

Have you had the lesion biopsied ____
By whom ________________ Pathology _________________________

Have you discussed having a Mohs procedure ____________________________________
With whom _______________

Family history of skin cancers? **NO/YES** Basal Cell ( ), Squamous Cell ( ), Melanoma **(**)
Who ____

Here to Discuss Aging Face: **YES** **NO**

Have you lost weight **NO** **YES** How much ___________________________
Have you gained weight **NO** **YES** How much ___________________________

What are your areas of concern
Brows **Nose** **Neck**
Eyelids (Upper/Lower) **Cheeks**
What are your concerns with this area ___________________________________

If your concern is your nose: **YES** **NO**

Do you have allergies **NO** **YES**
Have you had any trauma to your nose **NO** **YES**
If yes, please explain ____________________________________
Do you have any issues breathing
Right Nostril **NO** **YES**
Left Nostril **NO** **YES**
Both Nostrils **NO** **YES**
Any previous procedures on your nose ______________________________
By whom __________________ Date: ________________________
Do you desire cosmetic changes to your nose ___________________________

Here to Discuss Breast Surgery: YES NO

Present bra size ___________________ Desired Bra Size ________________________________
(NOT FOR BREAST REDUCTIONS)

Did you breastfeed your children **NO YES**

Are you still breastfeeding **NO YES**

If you have a child under 1 year old, when did you stop ______________________________

Do you have any personal or family history of breast cancer **NO YES**

Who ______________________

Do you have implants in now **NO YES**

Saline or Gel ______________ Size ________________________

Date of Breast Augmentation _________________________

Breast Augmentation Surgeon _________________________

Have you had any issues since they were put in **NO YES**

Prior Breast imaging (MRI, Ultrasound, Mammogram)____________Date:______________________

What are your concerns with your breasts ____

Here to Discuss your Abdomen: YES NO

Have you lost weight **NO YES** How much ____________________________________

Have you gained weight **NO YES** How much ____________________________________

Do you exercise **NO YES** How Often ____________________________________

Are you on a diet **NO YES** Describe: _______________________________________

What are your concerns with your abdomen ____

What is your goal ____

Here to Discuss Liposuction/Body Contouring: YES NO

Have you lost weight **NO YES** How much ____________________________________

Have you gained weight **NO YES** How much ____________________________________

Do you exercise **NO YES** How Often ____________________________________

Are you on a diet **NO YES** Describe:_______________________________________

What are your areas of concern

Abdomen	**Bra Rolls**	**Inner Thighs**	**Medial Knees**
Flanks	**Arms**	**Outer Thighs**	**Ankles**
Hips	**Back**		

What are your concerns____

What is your goal____

PATIENT NAME PRINTED:___________________________________ DATE:_______________________