St. Croix Plastic Surgery & MediSpa
Personal History

This information is confidential and will not be released except with your authorization Date:____________

LAST NAME:____________ FIRST:____________ MIDDLE:____________ DOB:____________ AGE:______

Ht:__________ Wt:__________ Sex M F Marital Status: ❍Single ❍Married ❍Widowed ❍Divorced

Date of last physical exam:__________ Doctor:__________ Referring Doctor:__________ Phone:__________

Purpose of this consultation:______________________________

PAST MEDICAL HISTORY : DO YOU HAVE OR HAVE YOU HAD? (IF YES, GIVE DATE OF OCCURRENCE)

AIDS or HIV	N	Y________	BLEEDING TENDENCIES	N	Y________	ASTHMA	N	Y________
THYROID	N	Y________	BLOOD PRESSURE	N	Y________	LUPUS	N	Y________
HEART	N	Y________	LUNGS	N	Y________	CANCER	N	Y________
KIDNEYS	N	Y________	NERVOUS PROBLEMS	N	Y________	FIBROMYALGIA	N	Y________
GALL BLADDER	N	Y________	BLEEDING PROBLEMS	N	Y________	ARTHRITIS	N	Y________
STOMACH	N	Y________	DIABETES	N	Y________	SCLERODERMA	N	Y________
HEPATITIS	N	Y________						

Other serious illnesses that you have had:______________________________

Do you regularly smoke? Y N How much per day?__________ Do you regularly drink over 3 cups of coffee per day? Y N

Do you regularly drink alcohol or beer? Y N How much per week?__________

MEDICATIONS: Are you presently taking any of the following? (Circle)

Aspirin/Anacin	Antibiotics	Blood Pressure pills	Insulin/Diabetic pills	Iron
Bufferin	Dilantin	Cortisone	Blood Thinners	Sleeping pills
Motrin	Hormones	Cough Medicine	Antibiotics	Phenobarbital
Ibuprofen	Thyroid pills	Birth Control	Digitalis	Water pills

Arthritis Medication Other Medication not listed:______________________________

Do you take herbal supplements Yes No If yes, what are they?______________________________

Aspirin and aspirin type products can cause excessive bleeding during surgery.

DRUGS OR SUBSTANCES TO WHICH YOU AR ALLERGIC:______________________________

FAMILY HISTORY: HAVE BLOOD RELATIVES HAD (PLEASE CIRCLE AND GIVE REASON)

High Blood Pressure__________ Arthritis__________ Asthma__________

Diabetes__________ Stroke__________ Goiter__________

Bleeding Disorders__________ Breast Cancer__________ Other Cancer__________

PLEASE LIST ANY SERIOUS ILLNESSES OR INJURIES AND DATES:

Illness/Injury__________ Year______ Illness/Injury__________ Year______

OPERATIONS: PLEASE LIST OPERATIONS AND YEAR:

Operation__________ Year______ Operation__________ Year______

Operation__________ Year______ Operation__________ Year______

WOMEN ONLY

Is there a chance you may be pregnant? Y N Regular Menses Y N Date of last menstrual period?__________

Any complications with pregnancies?______________________________

How many pregnancies?__________ How many children?__________ Did you breast feed? Y N How many?______

Last Mammogram?__________ Date:__________ ❍ Normal ❍ Abnormal

Specify Abnormality______________________________

Breast Cancer L R Date:__________

Mastectomy__________ Date:__________ Breast Biopsy L R Date:__________

Oncologist:__________ Surgeon for Breast Biopsy:__________

Address:__________ Address:__________