Lucie Capek, MD Plastic Surgery

MEDICAL HISTORY **Today's Date_____**

Patient Name_____ Age_____

Gender M__ F__ Height_____ ft_____inches Weight_____ lbs

For internal use: Weight_____lbs BMI _____ BP ____/_____ HR _____ RR_____

1. **ALLERGIES** - *List drug and type of reaction you have i.e. rash, breathing difficulty, etc.*

_____

Are you allergic to: LATEX Y__ N__ Adhesive tape Y__ N__ Epinephrine/Adrenaline Y__ N__

2. **MEDS** - *List any prescription or non-prescription **medications** you are currently taking:*

_____

_____

Do you take: Aspirin Y__ N__ NSAIDS Y__ N__ Hormones Y__ N__ Steroids Y__ N__

3. **SUPPLEMENTS** - *List any **vitamins or supplements** you are currently taking:*

_____

Do you take: Fish oil Y__ N__ Vit E Y__ N__ Green Tea Y__ N __

4. **MEDICAL HISTORY/SYMPTOMS** – *Check all conditions that you have **currently** or in the **past** and who treats you for them, if applicable:*

- o ADHD_____
- o Anxiety_____
- o Arrhythmia_____
- o Arthritis_____
- o Asthma_____
- o Bladder problems_____
- o Bleeding disorder_____
- o Blood Clots _____
- o Breast biopsy_____
- o Breast Cancer_____
- o Cold Sores_____
- o COPD or Emphysema_____
- o Dental Problems_____
- o Depression_____
- o Diabetes_____
- o Dry Eyes_____
- o Eating Disorder_____
- o GERD/Reflux_____
- o Heart Attack/ MI_____
- o Heart Disease_____*
- o Heart Murmur_____*
- o Hepatitis _____
- o High Cholesterol_____
- o HIV_____
- o Hypertension_____
- o IBS or IBD_____
- o Kidney Disease_____
- o Liver Disease_____
- o Nasal Obstruction/Injury_____
- o Neurological problem_____
- o Orthopedic Implant_____*
- o Polycystic Ovaries_____
- o Seizures/Stroke/Fainting_____
- o Skin Cancer_____
- o Sleep Apnea _____
- o Surgery: **LIST on next page**
- o Thyroid problem_____
- o TMJ problems _____
- o Transfusion _____
- o Varicose Veins_____
- o Vision Problem: Type_____
- o Weight loss over 30 lbs_____
- o OTHER: MEDICAL hospitalization

_____

_____

_____

* Do you require antibiotic prophylaxis for starred conditions listed Y___ N ___

5. **GYN History-** *Complete below, including number of each where applicable.*

Pregnancies: ____ Vaginal Deliveries____ C-Sections:____ LMP:Date _____ Menopause Y___ N ___

Last Gyn Exam: Date_____ Last mammogram: Date_____ Location: _____

6. **SURGICAL HISTORY-** *Check all PROCEDURES you have had, when and by whom:*

- o Blepharoplasty_____
- o Browlift_____
- o Rhinoplasty_____
- o Septoplasty_____
- o Chin Implant/Augmentation_____
- o Jaw or TMJ surgery_____
- o Otoplasty (ear pinning)_____
- o Facelift_____
- o Necklift_____
- o Thyroid surgery_____
- o Neck liposuction_____
- o Fat grafting/transfer_____
- o Breast Augmentation_____
- o Breast Lift_____
- o Breast Reduction_____
- o Mastectomy _____
- o Lumpectomy_____
- o Breast Reconstruction: Type:_____
- o Gynecomastia correction (men)_____
- o Liposuction: *Check type & areas treated*
  - o Standard (mechanical)
  - o LASER LipoPlasty
  - o Ultrasound-assisted

  _____
- o Abdominoplasty (tummy tuck)_____
- o Hernia repair_____
- o Bowel surgery/Appendectomy_____
- o Gallbladder removal _____
- o Hysterectomy/GYN surgery _____
- o Labiaplasty _____
- o Buttock Lift_____
- o Buttock Augmentation_____
- o Thigh Lift – Inner or Outer_____
- o Varicose or spider vein tx._____
- o Orthopedic surgery_____ _____
- o Major trauma_____

List any OTHER previous surgical procedures dates: _____

7. **COSMETIC HISTORY –** *Check all that apply and specify name of treatment and area(s) treated:*

- o Botox/Dysport/Xeomin:_____
- o Facial Fillers: _____
- o Fat or cellulite reduction: _____
- o Hydrafacial or Chemical Peel: _____
- o Laser Hair Removal:_____
- o Laser Rejuvenation: _____
- o Laser spider vein tx:_____
- o Micro-needling: _____
- o Sculptra or Kybella:_____

8. **ANESTHESIA** – *List any problems that YOU or a FAMILY MEMBER have had with anesthesia:*

_____

Do you have: dentures Y__ N __ Partial plate Y__ N __ Capped teeth Y__ N __

9. **SOCIAL HISTORY** – *List your DAILY consumption of the following:*

Alcohol: _____ Nicotine: Cigarettes: _____ E-Cigs _____ Vaping _____ Patch/Gum _____ Other_____

Marijuana _____ Recreational Drugs: Type_____

10. **FAMILY HISTORY** – *Check all that apply to any FAMILY MEMBER:*

- o Skin Cancer_____
- o Heart Disease_____
- o Diabetes_____
- o Breast Cancer_____
- o Bleeding/Clotting Disorder_____
- o Other_____

I certify that the above history is true and accurate to the best of my recollection:

Signature_____ Date_____

Relationship to Patient : _____Self _____Parent or Guardian