The PLASTIC SURGERY GROUP
Confidence is Beautiful®

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MEDICAL HISTORY FORM

Patient Name: _____ **Date:** _____

Primary Care Physician: _____

Allergies: _____

Hospitalizations/Surgeries: _____

Medical Conditions	**Y**	**N**		**Y**	**N**	
High Blood Pressure	☐	☐	Stroke	☐	☐	
Heart Murmur	☐	☐	Asthma	☐	☐	
Mitral Valve Prolapse	☐	☐	History of Melanoma	☐	☐	Father Mother Brother Sister Son Daughter
Heart Attack	☐	☐	Skin Cancer	☐	☐	Type: _____
Heart Bypass Surgery	☐	☐	Cancer	☐	☐	Type: _____
Pacemaker	☐	☐	Transplant	☐	☐	Type: _____
Diabetes	☐	☐				

Other Conditions Not Listed Above: _____

Date of last **Tetanus Shot**: _____

Do you take **blood thinners**? Yes / No

Medication List (Medications you are currently taking):

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Do you take **Aspirin** daily? Yes / No

Do you use Alcohol? Never / Socially / Daily

Smoking History: Currently / Formerly / Never

If smoking currently, please list frequency: _____

Date Medical History Updated: _____ Parent/Guardian Signature: _____

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