HEALY PLASTIC SURGERY

PATIENT HISTORY AND PHYSICAL FORM:

Name_____Sex___Age___Birthdate_____Ht_____
Type of Surgery_____Scheduled Date_____Wt ____

	NO	YES
Have you ever had any type of heart trouble		
Heart murmur or rheumatic fever, irregular heartbeat	☐	☐
Angina or heart pains	☐	☐
Heart attack	☐	☐
High blood pressure	☐	☐
Enlarged or weak heart	☐	☐
Pacemaker/Defibrillator	☐	☐

When and where was your last EKG? _____

Do you ever have difficulty breathing?	☐	☐
Do you have asthma, shortness of breath, or sleep apnea?	☐	☐
Do you have chronic cough or bronchitis?	☐	☐
Do you have a cough, cold, runny nose, or sore throat?	☐	☐

When was your last chest x-ray taken? _____

Have you ever had any type of liver trouble, hepatitis, or jaundice?	☐	☐
Do you have diabetes mellitus?	☐	☐
Do you have trouble with your stomach or intestines?	☐	☐
Have you ever had kidney infections, kidney stones, or kidney failure?	☐	☐
Have you ever had seizures, convulsions, or stroke?	☐	☐
Have you ever had anemia, excessive bleeding, blood clot, pulmonary embolism, or required a blood transfusion?	☐	☐
ÅCaprini Score: _____		
Do you have any relatives, who have had an allergic reaction to anesthesia, or death related to anesthesia or surgery?	☐	☐
Are you pregnant?	☐	☐

When was your last Menstrual period? _____

Do you drink alcohol? How much? _____
Do you smoke? How much? _____
Are you allergic or sensitive to any drugs/latex/food? (List)
_____
Please list all medications or pills that you take including vitamins, herbs, etc. _____
_____
Previous surgeries: _____
Any unusual reactions to anesthesia:_____