

ARTHUR W. PERRY MD, FACS PLASTIC SURGERY

MEDICAL HISTORY

Name _____ Age _____ Date _____

Medical Problems –check if you have the following problems

- | | | | | |
|---|--|--|---|---|
| ☐ Chest Pain | ☐ Jaundice/Liver Disease | ☐ Asthma | ☐ Blood clots in legs | ☐ Malignant Hyperthermia |
| ☐ Heart Disease | ☐ HIV+(AIDS) | ☐ Anemia | ☐ Neurologic disease | ☐ Anesthesia Problems |
| ☐ Hypertension | ☐ Lung Disease | ☐ Easy Bleeding or Bruising | ☐ Skin cancer | ☐ Thyroid disease |
| ☐ Diabetes | ☐ Bronchitis or emphysema | ☐ Stroke | ☐ Easy Fainting | ☐ Covid Vaccine received |
| ☐ Kidney Disease | ☐ Glaucoma | ☐ Cancer | ☐ Sleep apnea | |
| ☐ Hepatitis A,B or C | | | ☐ Arthritis or Rheumatic Disease | |

Other medical problems not listed above _____

List **Allergies** or circle **none** _____

Name & Phone number of **personal physician** _____

Month & Year of **last physical examination** _____

Have you ever used Accutane _____ Steroids _____ Narcotics for more than 1-week _____

List **medications** and doses – include birth control, GLP-1s, nonprescription drugs, vitamins, and herbs: _____

Social History

How many drinks of **alcohol** do you drink/wk? _____ Do you **smoke**? _____ How much? _____ Year stopped _____

Do you have any risks for **AIDS**? _____ Injected **drugs**? _____ type _____ tattoo or body piercing _____

Have you ever had **emotional problems**? _____ Name & Phone of therapist _____

Past Surgical History

List type and year of *any* non-plastic surgery _____

List type and year of *any* plastic surgery _____

For facial rejuvenation patients, circle problems you have

- | | | | |
|---|--|--|--|
| ☐ Drooping brows | ☐ Skin discoloration | ☐ Crepey cheek skin | ☐ Protruding ears |
| ☐ Fine wrinkling | ☐ Wrinkles of forehead/crow's feet/ between brows | ☐ Marionette lines | ☐ Deep nasolabial folds |
| ☐ Excess skin/fat of eyelids | | ☐ Bands in neck | ☐ Loose neck skin |
| | | ☐ Jowls | |

Do you wear glasses or contacts? _____ Name & Phone of ophthalmologist _____

Have you had? ☐ Eye surgery _____ ☐ Eye trauma _____ ☐ Prior Lasik _____ ☐ Dry eye symptoms _____ ☐ Facial palsy _____

List skin creams you use _____) _____

For nasal surgery patients, circle problems you have:

- | | | | |
|---|----------------------------------|---|---|
| ☐ Nose too large | ☐ Hump | ☐ Asymmetric | ☐ Fractured nose |
| ☐ Chin too small | ☐ Twisted | ☐ Breathing problems | ☐ Prior surgery |
| | | | ☐ Wide tip |

For body contouring and liposuction patients:

Height _____ Weight _____ Areas of concern _____

☐ Prior pregnancy ☐ C-section ☐ Abdominal scars ☐ Plan to have more children?

For breast surgery patients, circle problems that you have:

Bra size _____ Desired bra size _____ Date of last mammogram _____

- | | | | |
|-----------------------------------|---|--|--|
| ☐ Drooping | ☐ Back/neck pain | ☐ Prior surgery | ☐ Family history of breast cancer |
| ☐ Rashes | ☐ Asymmetry | ☐ Bra straps hurt | |

Procedure(s) desired _____

I certify that the above information is correct. I understand that purposely omitted information interferes with the delivery of medical care and will result in the termination of our doctor/patient relationship.

Signature _____
8/26