Carolinas HealthCare System

Cleveland Plastic and Hand Surgery – Patient History

Name: _____ Date: _____

Primary Care Physician: _____

Referring Physician: _____

Reason for Visit: _____

Current Medications – Prescription and over the counter medications
(Including vitamins, herbs, aspirin, antacides, injectables, hormones and birth control medication)

	Medication	Dosage	How often do you take this?
1.			
2.			
3.			
4.			
5.			
6.			

Do you have any allergies to latex or any medications? ☐ No ☐ Yes *(please list below)*

_____

Prior Medical History and General Information *(Check any and all that apply)*

Autoimmune Disease:
☐ Lupus
☐ Thyroiditis
☐ Rheumatoid Arthritis
☐ Other: _____

☐ **Bleeding/Clotting Problems**

Liver Disease:
☐ Hepatitis; ☐ A ☐ B ☐ C
☐ Cirrhosis

Diabetes (Controlled by):
☐ Injections ☐ Medication ☐ Diet

Heart Disease:
☐ Arrhythmias, irregular heart beat
☐ Murmur +/- antibiotics
☐ Heart Attack
☐ Heart Surgery: Type: _____
☐ Pace Maker
☐ Defibrillation
☐ Stent: When: _____

HIV/AIDS:
Tested? ☐ No ☐ Yes, results: _____
Date: _____

Kidney Disease:
☐ Dialysis
☐ Other: _____

Neurological Disease:
☐ Type: _____

Cancer:
☐ Location: _____

Skin Problems:
☐ Keloid/Thick Scarring

☐ **Stroke/Mini-Stroke**
☐ **Lung Disease**
☐ **High Blood Pressure**

Transplant:
☐ Type: _____

Tuberculosis:
Tested? ☐ No ☐ Yes, results: _____

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Past Medical Illnesses/Hospitalizations and Approximate Dates:

Previous Surgeries and Approximate Dates:

Any joint replacements/internal prosthesis? ☐ No ☐ Yes, type: _____

Any other major/chronic health problems? ☐ No ☐ Yes, type: _____

Family History: *(Place a mark if any blood relative has had any of the following)*

☐ Breast Cancer ☐ Melanoma ☐ Diabetes
☐ High Blood Pressure ☐ Ovarian Cancer ☐ Heart Disease
☐ Hemophilia ☐ Blood Clots ☐ Colon Cancer
☐ No Known Conditions ☐ Problems with Anesthesia
☐ Other: _____

Social History:

Do you currently smoke? ☐ No ☐ Yes, amount per day: _____
Are you a former smoker? ☐ No ☐ Yes, when did you quit: _____
Do you drink alcohol? ☐ No ☐ Yes, amount per week: _____
Occupation: _____
Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widow
Number of Children: _____
Do you plan on having more children? ☐ No ☐ Yes

Review of Systems: *(Check YES or NO if you have had any of the following symptoms in the past year)*

Weight Changes	☐ No	☐ Yes
Chest Pain	☐ No	☐ Yes
Jaundice	☐ No	☐ Yes
Seizures	☐ No	☐ Yes
Joint Pain	☐ No	☐ Yes
Chronic Cough	☐ No	☐ Yes
Easy Bruising	☐ No	☐ Yes
Fever Blisters	☐ No	☐ Yes
Swollen Ankles/Feet	☐ No	☐ Yes
Problems Swallowing	☐ No	☐ Yes
Nausea/Vomiting	☐ No	☐ Yes
Rapid Heart Beat	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Easy Bleeding	☐ No	☐ Yes
Muscle Pain	☐ No	☐ Yes
Shortness of Breath	☐ No	☐ Yes
Trouble Urinating	☐ No	☐ Yes
Dry Eyes	☐ No	☐ Yes
Fever/Chills	☐ No	☐ Yes

For Women Only:

Have you had a mammogram?	☐ No	☐ Yes
Do you do regular breast exams?	☐ No	☐ Yes
Have you had breast lumps?	☐ No	☐ Yes
Have you had breast discharge?	☐ No	☐ Yes
Did you breast feed?	☐ No	☐ Yes
Have you had a C-section?	☐ No	☐ Yes
Are you pregnant?	☐ No	☐ Yes
Do you plan to become pregnant?	☐ No	☐ Yes