DAVID STEPHENS MD

PLASTIC SURGERY | AESTHETICS

Date_____

PATIENT MEDICAL HISTORY

Patient Last Name	First Name	Middle Name

Date of Birth	Age	Height	Weight	Weight changes in the last 5 years	Gain/Loss Lbs

Name of Primary Care Physican	Phone Number	Date of last physical?	Did it include an EKG?	Date of last mammogram?
			Yes ☐ No ☐	

Please check all that apply:

- ☐ Hypertension
- ☐ Angina
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Arrhythmia
- ☐ Stroke/TIA
- ☐ Lung Disease/Type:_____
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Kidney Stones or Kidney Disorders
- ☐ Liver Disease/Viral/Type:_____
- ☐ Stomach Ulcers
- ☐ GERD
- ☐ Blood Transfusion
- ☐ History of Clotting Disorder
- ☐ Leukemia/Blood Disorders
- ☐ Cancer/Type:_____
- ☐ Autoimmune/Inflammatory Disease
- ☐ Diabetes/Type:_____
- ☐ Thyroid Disease
- ☐ Epilepsy/Seizures
- ☐ Migraines/Headaches
- ☐ Reproductive Disorders
- ☐ AIDS/HIV
- ☐ Dentures/Veneers/Implants
- ☐ Keloids or Thick Scars
- ☐ Skin Sensitivities
- ☐ Eczema
- ☐ Cold Sores
- ☐ Wound Healing Complications
- ☐ Special Diet
- ☐ Vegan/Vegeterian
- ☐ Current or Past Use of Fillers
- ☐ Current or Past Use of Botox or other Neuromodulators
- ☐ Facial Implants (including thread lifts)
- ☐ Orthopedic Implants

Do you have any drug allergies or sensitivities? Yes ☐ No ☐ If yes, please list: _____

_____

Do you have any latex allergies or sensitivities? Yes ☐ No ☐ If yes, please list: _____

_____

Are you allergic to adhesive tape? Yes ☐ No ☐

Are you allergic to suture material? Yes ☐ No ☐

Have you ever had a reaction to ***general*** anesthesia? Yes ☐ No ☐ If yes, please explain:____

_____

Have you ever had a reaction to ***local*** anesthesia? Yes ☐ No ☐ If yes, please explain:_____

_____

Have any ***family*** members had a reaction to anesthesia? Yes ☐ No ☐ If yes, please explain:

_____

Do you consider yourself a slow healer? Yes ☐ No ☐
Are you taking aspirin or blood thinners? Yes ☐ No ☐ If yes, type?_____
Do you bleed easily? Yes ☐ No ☐ Do you bruise easily? Yes ☐ No ☐

Previous Surgery: please list all previous surgeries and/or procedures:

Procedure	Date	Physician/Location

Medications, Drugs and Supplements: Please list ***all*** medications that you take on a daily basis including vitamins, supplements, aspirin, ibuprofen, homeopathic remedies, birth control products and estrogen.

Medication	Dosage (if you know)

Have you ever taken anabolic steroids? Yes ☐ No ☐
Do you experience shortness of breath after walking up two flights of stairs? Yes ☐ No ☐
Are you opposed to having a blood transfusion? Yes ☐ No ☐

Have you ever seen or been referred to a mental health counselor, psychiatrist, or psychologist? Yes ☐ No ☐

If yes, please explain: _____

_____

Please list your ***daily*** and ***weekly*** consumption of the following:

	Daily	**Weekly**
Alcohol		
Tobacco		
Vape		
Marijuana		
Recreational/Street Drugs		

Family History: Do you have a ***family history*** of any of the following:

High Blood Pressure Yes ☐ No ☐ If yes, relationship: _____

Heart Disease Yes ☐ No ☐ If yes, relationship: _____

Cancer Yes ☐ No ☐ If yes, relationship: _____

Diabetes Yes ☐ No ☐ If yes, relationship: _____

Lung Disease Yes ☐ No ☐ If yes, relationship: _____

Kidney Disorder Yes ☐ No ☐ If yes, relationship: _____

Bleeding Disorder Yes ☐ No ☐ If yes, relationship: _____

Asthma Yes ☐ No ☐ If yes, relationship: _____

- I understand and hereby affirm that the information given above is accurate and complete to the best of my knowledge.
- I hereby authorize David Stephens, MD, to release medical information accumulated in the course of my examination and/or treatment to any other doctor, hospital, nursing home or insurance company. I authorize the release of medical information contained in any doctors or hospital records to Dr. Stephens. I hereby agree to full responsibility for all expenses incurred by or on the account of the above named patient.

Signature _____ Date _____

Signature _____ Relationship _____ Date _____