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/Kidney Disorders
☐Liver Disease/Viral/Type:_____
☐Ulcers
☐GERD
☐Blood Transfusion
☐History of Clotting Disorder
☐Leukemia/Blood Disorder
☐Cancer/Type:_____
☐Autoimmune/Inflammatory Disease
☐Diabetes/Type:_____
☐Thyroid Disease
☐Epilepsy/Seizures
☐Migranes/Headaches
☐Reproductive Disorders
☐AIDS/HIV
☐Dentures/Veneers/Implants
☐Keloids
☐Skin Sensitivities
☐Eczema
☐Cold Sores
☐Wound Healing Complications
☐Special Diet
☐Vegan/Vegetarian
☐Current/Past Use Fillers
☐Current/Past Use BOTOX
☐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 on blood thinners? ☐Yes ☐No Do you bleed easily? ☐Yes ☐No Do you bruise easily? ☐Yes ☐No

Please list all previous surgeries and 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

Have you ever taken anabolic steriods? ☐Yes ☐No

Do you experience shortness of breath after walking up two flights of stairs? ☐Yes ☐No

Does your religion prohibit you from 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		

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_____