Middle Tennessee Plastic Surgery, P.C.
Patient History Form

Please answer all the questions as accurately as possible. If you do understand a question, please ask for assistance.

Patient Name___________________________ **Birth Date**__________________________

Primary Care Doctor____________________ **Referring Doctor**____________________

Drug Allergies: Name of Drug Type of Reaction

________________ ____

________________ ____

________________ ____

________________ ____

Previous Surgeries:

List any medications you are taking and their dosages:

Family History

Has any blood relative ever had the following:

Breast Cancer…….. No Yes High Blood Pressure…. No Yes Kidney Disease…….. No Yes
Melanoma………… No Yes Heart Disease………… No Yes Depression………… No Yes
Stroke…………….. No Yes Diabetes……………….No Yes

Past Medical History

Have you ever had the following:

Heart Disease…….. No Yes Cancer………………. No Yes Stomach Ulcer……… No Yes
Arthritis…………... No Yes Glaucoma…………… No Yes Kidney Disease……... No Yes
Asthma…………… No Yes Thyroid Disease…….. No Yes Anemia……………... No Yes
AIDS or HIV+ …… No Yes Bleeding Tendency… No Yes Tuberculosis…………No Yes
Stroke…………….. No Yes Diabetes…………… No Yes High Blood Pressure...No Yes

Review of Symptoms

Do you have now or have you had within the last year:

Weight Change…… No Yes Swollen Feet/Ankles….No Yes Seizures……………….. No Yes
Dry Eyes…………... No Yes Skin Rash…………….. No Yes Joint or Muscle Pain….. No Yes
Chronic Cough……. No Yes Chronic Diarrhea…….. No Yes Swollen Lymph Nodes…No Yes
Chest Pain………… No Yes Jaundice……………… No Yes Easy Bleeding………… No Yes
Rapid Heart Beat….. No Yes Depression…………… No Yes Easy Bruising…………. No Yes

Women Only

Date of Last Mammogram______________ History of Breast Lump or Discharge____________________

Social

Smoking (Type and amount per day)___________________ If former smoker, date quit:______________
Age_______ Height____________ Weight_______________
Marital Status (circle one): Single Married Separated Divorced Widowed

I verify that the above information is true and accurate to the best of my knowledge.

X____ ____________________________
Signature of Patient or Parent if Minor Date