Carolina Plastic Surgery, PA — History & Physical — The Vein Center — Revised 10/2013

Name_____ Age_____ Date_____

Referred By: _____

Reason for today's visit, brief history and if injury, date of injury:_____

_____

MEDICAL HISTORY:

1) Previous or Current Medical Problems: _____

_____

_____

2) Do you have or have you ever had any form of hepatitis or HIV?_____

_____

3) ALLERGIES TO MEDICATIONS:_____

ALLERGIES TO FOODS:_____

Are you allergic to iodine (shellfish, IVP dye for kidney x-rays or dye for arteriogram)? Yes No

Are allergic to latex (natural rubber, bananas or kiwi)? Yes No

4) Medication you take regularly or occasionally

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you ever take diuretics (water pills)? Yes No

5) Do you bruise easily? Yes No

Have you ever had problems with bleeding during surgery? Yes No

Do you ever take aspirin or aspirin products, such as:Goody or BC Powder, Motrin, Advil, Nuprin Ibuprofen, Naprosyn, Anaprox, Other:_____, or any on the list of products and medications included in your packet? Yes No

If yes, please list:_____

Do you take vitamins and/or herbs (Fever Few, Green Tea, Ginko Biloba, Willow Bark, Vitamin A, Vitamin E, etc.)? Yes No

If yes, please list: _____

6) Past Surgical Procedures and/or Hospitalizations (include dates):

_____

_____

_____

_____

7)Have you had any anesthesia-related problems during or after surgery? Yes No

If yes, please explain:_____

_____

8) Have you or a family member ever had a high fever during or immediately after surgery?

Yes No

If yes, please explain:_____

_____

9) Does anyone in your family have a history of malignant hyperthermia? Yes No

If yes, please explain:_____

_____

10) Do you have a high temperatur/fever after exercising? Yes No

FAMILY HISTORY:
Has anyone in your family had any of the following:

Heart Disease? No Yes Who?_____

High Blood Pressure? No Yes Who? _____

Cancer? No Yes Who? _____

Diabetes? No Yes Who? _____

EENT: Do you ever have problems with your eyes, ears, nose, or throat? Yes No

If yes, explain: _____

_____

Do you smoke? (If yes, how many packs per day and for how long?_____) Yes No

Does your spouse or anyone in your household smoke? Yes No

Cardiovascular: Do you have any problems with your heart (chest pain, heart attack, high blood pressure, heart murmur)? Yes No

If yes, explain:_____

Do you ever get short of breath? Yes No

Do your ankles ever swell? Yes No

GI:

Do you have problems with ulcers? Yes No

Have you ever vomited blood? Yes No

Have you ever passed blood in your stools? Yes No

Do you have diabetes? Yes No

Have you had gallbladder trouble? Yes No

Have you ever had yellow jaundice? Yes No

GU:

Have you ever had any trouble with kidney stones?	Yes	No
Have you ever had any trouble with kidney infections?	Yes	No
Do you have trouble with bladder infections?	Yes	No
Men: Do you have prostate trouble?	Yes	No
Women: Are your periods regular?	Yes	No
Any excessive bleeding?	Yes	No
Is there a chance you could be pregnant?	Yes	No
Neuromuscular: Do you have seizures?	Yes	No
Have you ever had a stroke?	Yes	No
Miscellaneous: Have you ever had blood clots in your legs (phlebitis)?	Yes	No
Have you ever had blood clots in your lungs(pulmonary embolus)?	Yes	No
Do you have any history or have you ever been told that you have any anxiety disorders? (i.e., panic/anxiety attacks, obsessive compulsive disorder, body dysmorphic disorder)?	Yes	No
Do you have sickle cell anemia?	Yes	No
Do you currently have any dental problem?(i.e., loose teeth, periodontal disease,	Yes	No

other) Please List:_____

Have you recently had a dental procedure? If so, what procedure? Yes No

_____

DO YOU HAVE OR HAVE YOU HAD ANY MEDICAL PROBLEMS THAT I HAVE NOT ASKED YOU ABOUT? Yes No

If yes, please explain:_____

_____

AN HONEST ANSWER TO THE FOLLOWING QUESTIONS ARE ABSOLUTELY CRUCIAL FOR YOUR SAFETY DURING ANESTHESIA:

Do you drink alcohol? Yes No

If yes: How much? _____ How often?_____

Do you now or have you ever used illegal street, or recreational drugs? Yes No

If yes, please explain: _____

_____

"The above information is correct and complete to the best of my knowledge"

BP: _____

Pulse: _____ (Signature)

Height: _____

Weight: _____

Checked By: _____ (Physician's Signature)