

UPMC Aesthetic Plastic Surgery Center

New Patient Health History Form

Patient Name: _____ Birthdate: _____ Today's Date: _____

Referring Physician: _____ Address: _____

Pharmacy Name: _____ Phone: _____

Reasons for today's visit: _____

Briefly describe the problem: _____

Please list prior surgeries:

Please list current and prior illnesses or injuries:

Please list all medications (prescriptions and non-prescriptions) that you take. Please include herbal remedies, vitamins, over-the-counter, illegal drugs

Do you take any blood thinning products such as Vitamin E, Plavix, Coumadin, or Aspirin?

Yes No

Do you have any food, environmental or drug allergies?

Yes, please explain: Allergy type: _____

Reaction: _____

No

Do you smoke?

Yes, please specify type (cigarettes, pipe, etc.): _____

How many a day: _____

How long have you smoked: _____

No

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Do you drink alcohol?

No Socially Daily

Beer/wine Hard liquor

Occupation: _____

Hand dominance: Right Left

Please describe any family health issues below

Mother:

Father

Sibling(s)

Other hereditary conditions

Patient Signature: _____ Date: _____

Physician Signature: _____ Date reviewed: _____

UPMC Aesthetic Plastic Surgery Center

New Patient Health History Form

Do you now have or have you ever had:

- | | | | |
|-------------------------------|-----------------------------|----------------------------------------------|-------|
| Fever or chills | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Unexplained weight loss | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Hepatitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| HIV/Other blood diseases | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Bleeding disorders | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Thyroid problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Arthritis | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Mobility/joint problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Constipation | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Diarrhea | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Blood in stool | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Nausea/vomiting | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Liver problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Heart problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Deep vein thrombosis/DVT | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Blood clots in lungs/legs | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| High blood pressure | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Asthma | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Sleep Apnea | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Breast abnormalities | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Nipple discharge | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Last mammogram | | Date: _____/_____/_____ | |
| Changes in moles | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Lesions | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Rashes | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| History of Keloids | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Neurological problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Headaches | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Genital or oral herpes | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Sexually transmitted diseases | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Blood in urine | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Urinary tract infection | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Problems urinating | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Prostate problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Kidney problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Vision problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Hearing problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Sinus problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Mood swings | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |
| Sleep apnea | <input type="checkbox"/> No | <input type="checkbox"/> Yes, please explain | _____ |

Please list any other conditions/illnesses not indicated above: _____

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes in my health.

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Review date:** _____