PATIENT HEALTH HISTORY

Patient name________________________________**Birthdate**_____________**SS#**_______________

Do you Take Vitamins/Minerals____

PAST MEDICAL HISTORY

MEDICAL HISTORY Have You Ever Had….? (Answer Yes or No)

Adhesive Allergy ________
Asthma ________
Bruise/Bleed easily ________
Breast Cancer ________
Cancer ________
Diabetes ________

Fibromyalgia _________
Glaucoma _________
Heart Disease _________
High Blood Pressure _____
Hepatitis __________
History of DVT ________

Keloids (thick scars)_________
Kidney Disease _________
Lung Disease __________
Mental/Nervous Disease _____
Migraines __________
Skin Cancer _________
Thyroid Disorder __________

PREVIOUS SURGERY (Please List)

Operation	Hospital	Date	Anesthesia	Surgeon

Serious Illness (Please List)

____

Anesthesia Complications after Surgery: Yes______ No_____ Explain___________________________

____

FAMILY HISTORY **If Yes please indicate the relationship**

Abnormal clotting___________________________
Auto Immune Disorder_______________________
Breast Cancer______________________________
Cancer ___________________________________
Diabetes__________________________________
Drug Allergies_____________________________
Heart Disease______________________________
Hemophilia________________________________
Blood Pressure_____________________________

Kidney Disease______________________________
Liver Disease_______________________________
Lung Disease_______________________________
Malignant Hypothermia_______________________
Skin Cancer________________________________
Substance Abuse____________________________
von Willebrand _____________________________

SOCIAL HISTORY

Do you Smoke? Yes____ No_____ How many packs a day?________________________________
Do you use E-cigarettes or Vape? Yes ____ No ____
Do you use any other nicotine products? Yes ____ No ____ What? ____________________________

General Health: Good___ _____Fair_______ Poor_________ If not "Good" please explain
____

Do You Exercise Yes_____ No_______ How Often_____________________________________

MEDICATIONS you are now taking including blood thinners, aspirin, bufferin, birth control pills, diuretics, blood pressure or heart medications, tranquilizers, hormones, ibuprofen, etc.

____

____

MEDICATION ALLERGIES____

Ability to Heal Please answer Yes or No

Skin appears fragile,burns easily____________
Form thick scars ________
Cold sores ____________

PRESENT HISTORY

Height_________Weight________ Last physical Exam:____

Have you had a recent pneumonia vaccine? Yes ________ No __________

Name and address of Doctor or Facility____

_________________________________ Patient Signature(If patient minor, parent must sign)

____________________ Date

Patient Name:____ **Date:** ______________
Birthdate: ________________ **Social Security Number:** _____________________________

Are you Pregnant Yes ______ No______

Breast Symptoms*: (if applicable)*

Unsatisfactory Appearance _______ Breast Pain ______ Nipple Discharge _______

Implant Problems ______ Upper BackPain ______ Rashes _______

Neck Pain ______ Lower Back Pain ______ Infections ________

Absence of Breast/Nipple ______ Shoulder Pain ______

Breast Mass/Lump ______

Breast Cancer Treatment:

Radiation Therapy: Yes ( ) No ( ) Date Completed ______________________
Chemotherapy YES ( ) NO ( ) Date Completed ______________________

Other: ____

Mammograms:

Date Location Findings

____

Breast Implant: **Do you currently have implants? Yes ______ No _______**

Type: Saline ____ Silicone Gel ____ Size in CC's: _________________

Position: Under muscle _____ Over muscle _____

Manufacturer: ____

____

Patient Signature **Date**

RECORDS RELEASE

Per HIPPA regulations, only physicians or persons listed below can receive your medical records from Bajaj Plastic Surgery. Please list any physician or person you want to be kept updated or informed regarding your care and treatment. **PLEASE FILL OUT ALL INFORMATION FOR THE PHYSICIAN OR PERSON LISTED ON THIS FORM.**

REFERRING DOCTOR: ____

PHONE: __________________________________

ADDRESS: ____
Street Suite

____
City State Zip

PRIMARY PHYSICIAN: ____

PHONE: __________________________________

ADDRESS: ____
Street Suite

____
City State Zip

ONCOLOGIST: ____

PHONE: __________________________________

ADDRESS: ____
Street Suite

____
City State Zip

OTHER DOCTOR OR PERSON: ____

PHONE: __________________________________

ADDRESS: ____
Street Suite

____
City State Zip

OTHER DOCTOR OR PERSON: ____

PHONE: __________________________________

ADDRESS: ____
Street Suite

____
City State Zip

I authorize my records to be sent to the above physicians or persons listed.

____ ____________________
Signature/Print Name Date