PLASTIC SURGERY CONSULTANTS

Medical Information Database/Pre-Op Assessment

Name _____ Date _____

Date of Birth _____

Reason for seeing physician _____

Referring Physician _____

Were you seen in the E.R.? YES / NO If YES, which hospital _____

Date of accident or injury _____

Primary Care Provider, Pediatrician, Family Doctor, and GYN, if you have one

_____

Previous Medical History

Do you have a latex allergy/sensitivity? YES / NO

If YES, what type of reaction _____

List all known drug allergies

_____

List all medications you are taking (OTC and prescribed) and the reasons. Include dose and frequency.

_____

_____

List any weight loss medications _____

List any medications you cannot take _____

_____

Preferred Pharmacy _____

Height and Weight _____ BMI _____

Immunizations

Please indicate date (month and year) of last immunization.

Tetanus Booster _____ Chicken Pox _____

DPT _____ Hepatitis B _____

MMR _____ Polio _____

Covid-19 Dose 1 _____ Covid-19 Dose 2 _____

Covid-19 Booster _____

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Current Medical Problems

YES	NO		YES	NO	
___	___	High Blood Pressure	___	___	Cardiac Disease/Heart Attack
___	___	Cancer	___	___	Diabetes
___	___	Immune Deficiency	___	___	Kidney Disease
___	___	Lung Disease	___	___	Substance Abuse
___	___	HIV/AIDS	___	___	Hepatitis A/B/C
___	___	Breast Disease	___	___	DVT/PE

If other, please explain _____

Review of Systems

YES	NO		YES	NO	
___	___	Fever	___	___	Vision Problems
___	___	Sinusitis	___	___	Chest Pain
___	___	Seizures	___	___	Constipation
___	___	Skin lesions that are changing	___	___	Coughing up blood
___	___	Excessive bleeding/easy bruising	___	___	Chills
___	___	Corrective lenses (glasses, contacts)	___	___	Sore Throat
___	___	Shortness of breath	___	___	Weakness/numbness
___	___	Sleep Apnea	___	___	Reflux
___	___	Diarrhea	___	___	Blood in urine
___	___	Jaundice	___	___	Weight loss or gain
___	___	Earaches	___	___	Wheezing/asthma
___	___	Heartburn	___	___	Fainting
___	___	Blood in bowel movements	___	___	Difficulty urinating
___	___	Depression or anxiety	___	___	Difficulty healing

Have you tested positive for Covid-19 within the past year? **YES** **NO**

If YES, when was your most recent positive test? _____

Previous Hospitalizations/Pregnancies

Date (month/year)	**Reason for Hospitalization**	**Difficulty with Anesthesia**
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO

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Past Surgical History

Date (month/year)	**Surgical Procedure**	**Difficulty with Anesthesia**
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO

Would you object to a medically necessary blood transfusion? **YES** **NO**

Last menstrual period _____ Any chance of being pregnant _____

Social History

Do you use tobacco/nicotine products of any kind? (ex. vapes, Zyn, chewing tobacco, cigarettes, e-cigarettes, nicotine gum, nicotine patch) YES NO Amount/Frequency _____

Do you drink alcohol? YES NO Amount/Frequency _____

Do you use illegal drugs? YES NO Amount/Frequency _____

Occupation _____

Living Situation (who is in your household) _____

Family History

	YES	**NO**	**Relationship**
High Blood Pressure	____	____	_____
Diabetes	____	____	_____
Breast Cancer	____	____	_____
Melanoma	____	____	_____
Other Cancers	____	____	_____
DVT/PE	____	____	_____

Date of most recent lab work, EKG, x-ray or diagnostic test _____

Location _____ Phone _____

Please list the two most important questions we can answer for you at your initial consultation:

_____

_____

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TO BE COMPLETED BY OFFICE STAFF:

Pre-Operative:

_____ CBC
_____ BMP
_____ H&H
_____ PT
_____ PTT
_____ UA Pregnancy

_____ CXR
_____ EKG
_____ Other:

Orders Mailed to Patient: _____
Order Given to Patient: _____

Reviewed on _____ by _____
Reviewed and updated on _____ by _____

*Instructed patient to fax results to surgery center? YES NO

Pre-Operative assessment completed by _____.

Date _____

Anesthesia reviewed by _____, MD.

Date _____

Patient is approved for outpatient surgery YES NO

ASA I ASA II ASA III (only with anesthesia consultation)