PLASTIC SURGERY
OF WESTCHESTER

General Patient Information

Patient Name: **Last**_____**First**_____**MI**_____

Age: _____

Health History

1. Do you have any medical problems? _____
2. Please list any medications you take:_____

   _____
3. Are you allergic to any medications? _____
4. Are you allergic to latex, iodine, contrast dye or shellfish? _____
5. Height:_____ Weight:_____

6. Do you have or had the following illnesses? (check all that apply)

a. Arthritis:	_____	High Blood Pressure:	_____
b. Blood Clots:	_____	Kidney Disease:	_____
c. Diabetes:	_____	Lung Disease:	_____
d. Heart Disease	_____	Stroke:	_____
e. Cancer (type):	_____	Other:	_____

Previous Surgeries/Major Illnesses

	Year	Reason	Outcome
Hospitalizations			
Serious Illness or injuries			
Pregnancy			
Operations			
Broken Bones			

Social History

Do you smoke? Yes No
How much? _____
Did you used to smoke? Yes No
How much? _____

Do you drink alcohol? Yes No
How much? _____
Do you use any drugs? Yes No
Please List:_____

Women Only

(Check all conditions you have or had)

Breast Lump: _____ Menstrual Problems: _____ Vaginal Infection _____
Breast Pain: _____ Menopausal Symptoms: _____ Nipple Discharge_____

Date of last mammogram: _____ Date of last Pap Smear:_____
Do you do regular breast self-examinations? Yes No
Could you be pregnant now? Yes No
# of pregnancies: _____ # of deliveries:_____
# of abortions: _____ # of miscarriages:_____

Is there any personal or family history of breast cancer? Yes No

Reason for Today's Visit

What are your major concern(s)? (Circle all that apply)

Face	Skin	Breasts	Thighs	Back
Eyes	Feet	Waist	Abdomen	Legs
Lips	Body	Buttock	Forehead	Neck

Please further describe your concern:

_____
_____
_____

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

_____ _____
Signature of patient or parent/guardian if a minor Date