MEDICAL HISTORY FORM | LEONARD PLASTIC SURGERY

Name _____ Primary Physician _____

PRESENT PROBLEM:

Specific problem(s) for which you are seeing Dr. Leonard: _____

_____

Other physicians, including plastic surgeons, you have consulted about this problem (include dates):

_____

Allergies **Frequency and duration of use**

1) _____ Coffee/Tea _____ /day for _____ yr.

2) _____ Tobacco _____ /day for _____ yr.

3) _____ Alcohol _____ /day for _____ yr.

All medications presently using and dosages/frequency

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Major Injuries/Illnesses **Year/Duration**

1) _____ _____

2) _____ _____

3) _____ _____

4) _____ _____

5) _____ _____

Previous Operations

1) _____ _____

2) _____ _____

3) _____ _____

4) _____ _____

5) _____ _____

Personal Medical History

Have you had any disorders of the following?

	Yes	No		Yes	No
Eyes & Ears	☐	☐	Nervous System	☐	☐
Nose/Sinus & Throat	☐	☐	Blood	☐	☐
Heart/Blood Vessels	☐	☐	Bones/Joints	☐	☐
Breasts	☐	☐	Urinary System	☐	☐
Lungs	☐	☐	Psychiatric	☐	☐
Gastrointestinal	☐	☐	Reproductive System	☐	☐
Liver	☐	☐	Other (Diabetes, etc)	☐	☐

Notes _____

_____

_____

_____

	Age	State of Health
Mother	____	_____
Father	____	_____
Brother(s)	____	_____
	____	_____
	____	_____
Sister(s)	____	_____
	____	_____
	____	_____
	____	_____
Children	____	_____
	____	_____
	____	_____
	____	_____
	____	_____

Family Medical History

Has any relative had:

	Yes	No
Tuberculosis	☐	☐
Cancer	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Diabetes	☐	☐
Kidney Disease	☐	☐
Asthma	☐	☐
Lung Disease	☐	☐
Blood Disorder	☐	☐
Epilepsy	☐	☐
Mental Disorder	☐	☐

Do you have high blood pressure? _____ Yes ☐ No ☐

Do you have shortness of breath with walking or when lying flat? _____ Yes ☐ No ☐

Have you ever had any chest pain? _____ Yes ☐ No ☐

Have you ever been found to have a heart murmur? _____ Yes ☐ No ☐

Have you ever had scarlet fever or rheumatic fever? _____ Yes ☐ No ☐

Do you have frequent infections or boils? _____ Yes ☐ No ☐

Have you ever taken steroid medications, cortisone, or ACTH? _____ Yes ☐ No ☐

Have you ever had a bad reaction to a local anesthetic? _____ Yes ☐ No ☐

Does your religion prohibit blood transfusions? _____ Yes ☐ No ☐

Do you have unusual bleeding from cuts, surgery, or tooth extractions? _____ Yes ☐ No ☐

Do you form large scars or keloids? _____ Yes ☐ No ☐

Have you ever had psychiatric care or been advised to see a psychiatrist? _____ Yes ☐ No ☐

Do you have or have you had any significant emotional problems? _____ Yes ☐ No ☐

Height _____ ft. _____ in. Weight _____ lbs. Weight change past year of _____ lbs. ☐ Loss ☐ Gain

Date of last menstrual period _____

Date of last physical exam: _____ Did it include EKG? ☐ Yes ☐ No

Chest X-Ray ☐ Yes ☐ No Examining Doctor _____

LEONARD
PLASTIC SURGERY