

# MEDICAL HISTORY

*Please print and complete all items*

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Date of last annual physical: \_\_\_\_\_

Were x-rays/lab work/EKG done? Please list, if any: \_\_\_\_\_

Please list abnormalities, if any: \_\_\_\_\_ Date of last tetanus shot: \_\_\_\_\_

*Female patients:* Date of last Gynecology checkup: \_\_\_\_\_ Last mammogram: \_\_\_\_\_

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## PRESENT CONCERN

Specific concern(s) for which you are seeing Dr. Fernandez: \_\_\_\_\_

Have you consulted any other doctors, including plastic surgeons, about this or other related concerns? \_\_\_\_\_

Name of doctor, type of consultation, date: \_\_\_\_\_

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## PAST MEDICAL HISTORY

Please rate your General Health: Good \_\_\_ Fair \_\_\_ Poor \_\_\_

Have you had any illnesses or disorders of the following? (circle if yes)

*Brain    Nervous System    Eyes    Nose    Sinuses    Throat    Lungs    Breasts*  
*Heart or Blood Vessels    Stomach    Intestines    Liver    Blood    Urinary System    Arms or Legs*  
*Reproductive System            Bones or Joints            Endocrine System or Diabetes*

Please explain reason for all body systems circled above and give dates and treatment: \_\_\_\_\_

Any other significant illnesses?: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight loss or gain in past year? \_\_\_ lbs. \_\_\_ Gain \_\_\_ Loss

Please explain reason for gain/loss: \_\_\_\_\_

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## PREVIOUS SURGERIES

*Operation    Year    Hospital    City (if not Bradenton)    Surgeon's Name    Anesthesia (local or general)*

Have you had any significant complications or after effects from any of these operations? Yes \_\_\_ No \_\_\_

If Yes, please explain \_\_\_\_\_

**PREVIOUS INJURIES**

<i>Type</i>	<i>Year</i>	<i>Hospital</i>	<i>Doctor</i>	<i>Any complications</i>

Please list your approximate daily consumption of the following in cups/ounces:

Coffee or tea \_\_\_\_\_ Alcohol \_\_\_\_\_

Daily consumption/use of tobacco products or snuff \_\_\_\_\_

Do you currently use non-prescription drugs? (Please specify last date of use/amount) \_\_\_\_\_

Does anyone else in your household smoke? Yes \_\_\_\_ No \_\_\_\_ How much? \_\_\_\_\_

PLEASE LIST ALL of your current medications. Include dosage and frequency of use as well as the prescribing physician. Please also list in addition to prescribed drugs all over-the-counter drugs, health store and herbal formulations. Include pills, liquids, creams, suppositories, inhalers, drops, and injections. (Such as birth control, diuretics, blood pressure or heart medication, tranquilizers, hormones, blood thinners, nose drops and sprays, inhaler medicines, rub-on medications, aspirin, bufferin, herbs, weight loss medication, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PERTINENT PRE-OPERATIVE INFORMATION:**

Are you allergic to any medications? Yes \_\_\_\_ No \_\_\_\_

If yes, which one(s) \_\_\_\_\_

Drug intolerance: \_\_\_\_\_

Have you ever reacted badly to being put to sleep for surgery? Yes \_\_\_\_ No \_\_\_\_

Has any member of your family ever reacted badly to being put to sleep for surgery? Yes \_\_\_\_ No \_\_\_\_

Have you required unusually large amounts of local anesthetic (Novocaine, etc.)? Yes \_\_\_\_ No \_\_\_\_

Are you allergic to suture material such as catgut? Yes \_\_\_\_ No \_\_\_\_

Do you have high blood pressure? Yes \_\_\_\_ No \_\_\_\_

Have you ever had scarlet fever or rheumatic fever? Yes \_\_\_\_ No \_\_\_\_

Do you bleed unusually easily (from cuts, surgery, tooth extractions)? Yes \_\_\_\_ No \_\_\_\_

Do you bruise easily? Yes \_\_\_\_ No \_\_\_\_

Are you a slow or poor healer? Yes \_\_\_\_ No \_\_\_\_

Do you form large scars or keloids? Yes \_\_\_\_ No \_\_\_\_

Do you have any skin disease, hives, eczema or rash? Yes \_\_\_\_ No \_\_\_\_

Do you have frequent infections or boils? Yes \_\_\_\_ No \_\_\_\_

Have you taken steroid medications, cortisone, or ACTH? Yes \_\_\_\_ No \_\_\_\_

If so, how long ago? \_\_\_\_\_

Do you have shortness of breath with walking? Yes \_\_\_\_ No \_\_\_\_

Do you have, or have you had any back or neck trouble? Yes \_\_\_\_ No \_\_\_\_

Does your religion prohibit blood transfusions? Yes \_\_\_\_ No \_\_\_\_

Do you have, or have you had any significant emotional problems? Yes \_\_\_\_ No \_\_\_\_

Have you ever had, or been advised to seek psychiatric care? Yes \_\_\_\_ No \_\_\_\_

I certify that the above information is correct. Signed: \_\_\_\_\_