JOSEPH R. BURLIN, MD, INC.
PLASTIC AND RECONSTRUCTIVE SURGERY
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STOCKTON, CALIFORNIA 95204

MEDICAL HISTORY DATABASE

I. INTRODUCTION

Bp ______________

Pulse ____________

BMI _____________

G_______P_______

Bra Now _________

Bra Goal _________

Name____

Age ___________________________Date today _______________________

Birthdate _______________________Height ___________________________

Weight today ___________________Weight ["ideal"] __________________

Is there any possibility that you could be pregnant at this time? ___________

Known Medical Problems or Issues:

1. ____
2. ____
3. ____
4. ____

Your Primary Care Physician:

Doctor's name ____

How long have you been under his care _________________________

Approximate date of your last physical examination _______________

Your Specialty Physicians who you have seen within the past 2 years:

1. Doctor ____

Specialty ____

When last seen _____________________________________

Why seen ____

2. Doctor ____

Specialty ____

When last seen ______________________________________

Why seen ____

Revised: 9/8/08

3. Doctor ____

Specialty ____

When last seen ____________________________________

Why seen ____

Current Medications. Please list all medications you are currently taking. Include all herbal, holistic, and over-the-counter medications as well. If possible, please include the strength and dosage information as well. If you need more room, please us the back of this page and check this box ❑.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. Do you take aspirin ____________________________________
8. Do you take Motrin, Ibuprofen, or Advil? ____________________
9. Do you take Aleve, Anaprox, or Naprosyn? ____________________
10. Do you use herbal or holistic medications of any kind? __________

    If yes, please list ____________________________________

11. Have you ever taken weight reduction medications? ____________

    Herbal or prescribed? _______________________________

    When was that? ____________________________________

Please list any and all allergies that you may have. [Examples include medications, foods, tape, latex, chemicals, products]:

1. ____
2. ____
3. ____
4. ____
5. ____

Hospitalizations. Please list any and all hospitalizations over the past 5 years.

1. Approximate date of admission ________________________

Reason for admission ____________________________

Doctor involved ________________________________

2. Approximate date of admission _________________________

Reason for admission ____________________________

Doctor involved ________________________________

3. Approximate date of admission _________________________

Reason for admission ____________________________

Doctor involved ________________________________

Previous Plastic, Cosmetic, or Reconstructive Surgery.

1. Approximate date of surgery ___________________________

Procedure ____________________________________

Surgeon [optional] ______________________________

2. Approximate date of surgery ___________________________

Procedure ____________________________________

Surgeon [optional] ______________________________

3. Approximate date of surgery ___________________________

Procedure ____________________________________

Surgeon [optional] ______________________________

II. BACKROUND INFORMATION

Please circle all that apply to you:

Smoke cigarettes currently

Have smoked cigarettes within the past 2 years

Drink alcohol. If yes, #drinks/day _______________________________

Alcohol use is a concern to you or others

Use any illicit drugs or medications (*all responses will be strictly confidential)*

Have a history of excessive bleeding or bruising

Have a history of anemia or low blood counts

Have a history of severe nausea or vomiting follow previous surgery

Have family history of problems or complications related to general anesthesia

Have a history of keloids, thick, or poor scars

Have a history of hepatitis

Have a history of HIV+ or AIDS (*all responses will be strictly confidential)*

Am currently on Dr. Burlin's SkinGlow program

Am currently on another skin program

Currently use Retin-A daily

Currently use a daily Glycolic Acid

Currently get facial "microdermabrasions" at least once every other month

Currently get a "facial" at least once every other month

Have had a "chemical peel" to my face in the past

Am NOT very good about using daily sunblocks

Have a history of "cold sores" to my lips

Have a history of skin cancer to my face

Have been on Accutane within the past 1 year

Have a tendency for "dry eyes"

Have problem with "excessive tearing" in either eye

Have removable dentures or dental appliances

Have a history of high blood pressure

Have a history of heart disease

Have been told you have "mitral valve prolapse"

Have ever had a "heart attack"

Have ever seen a cardiologist for any reason in the past 5 years

Who? ____

When? ____

For what reason? _____________________________________

Have had a “treadmill stress test” within the past 5 years

Have ever had a stroke

Have a pacemaker

Can NOT climb 2 sets of stairs without difficulty

Can NOT walk 3 blocks on level ground without difficulty

Have a history of blood clots in my legs

Have “asthma” or have ever had an “asthma-attack”

Have been told you have “bronchitis”

Have a “smoker’s cough,” especially in the morning

Have a history of thyroid problems

Have a history of diabetes

Have ever had a seizure

Have a problem with migraine headaches

Have ever been treated for a “psychiatric” problem

Have ever been treated for “depression”

Have “panic attacks”

Have ever been treated for an “anxiety” or “stress” related problem

Have ever been treated for alcoholism

Have a history or frequent bladder infections

Have had a problem with drug dependence

Have had previous abdominal surgery [abdominoplasty patients only]

Am not planning on having more children [abdominoplasty patients only]

Am easily prone to constipation

Have had a mammogram before.

If yes, date of last mammogram___________________________

If yes, where was it performed____________________________

Have had a breast biopsy

Have had breast cancer in the past

There is a history of breast cancer in my family [mother's side]

Have a history of "connective tissue disease"

Have a history of "autoimmune disease"

Have a history of nipple discharge

My breasts are uneven. [how? _________________________________]

III. **CERTIFICATION OF INFORMATION**

I certify that the information contained above is true, correct, and current to the best of my knowledge.

____

Patient's Full Name / Printed

____

Patients Signature

____

Date Signed