

# THE LA JOLLA INSTITUTE OF PLASTIC SURGERY

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NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ DATE: \_\_\_\_\_

GENERAL HEALTH IS? \_\_\_\_\_ HAVE YOU HAD A COLD/FLU IN THE PAST MONTH? \_\_\_\_\_

IF SO, WHICH ? \_\_\_\_\_ WHEN? \_\_\_\_\_ ARE YOUR SYMPTOMS STILL PRESENT? \_\_\_\_\_

RACIAL (ETHNIC) BACKGROUND \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ MAXIMUM PREVIOUS WEIGHT: \_\_\_\_\_

HAVE YOU EVER HAD, OR BEEN TOLD YOU HAD ANY OF THE FOLLOWING CONDITIONS?

	YES	NO		YES	NO
HEART TROUBLE			GLAUCOMA/EYE DISORDER		
HEART ATTACK			VISUAL DISTURBANCES		
HEART PAIN			ERROR IN REFRACTION		
PALPITATION/IRREGULAR PULSE			OTHER EYE PROBLEMS		
EXTRA HEART BEATS			HEPATITIS A, B OR C (please circle)		
STROKE			YELLOW JAUNDICE		
HYPERTENSION			GALLSTONES/GALLBLADDER TROUBLE		
BLOOD PRESSURE ABNORMALITIES			CIRRHOSIS OF THE LIVER		
ABNORMAL EKG			ALCOHOLISM		
RHEUMATIC FEVER			ESOPHAGEAL VARICES		
DROPSY OR HEART FAILURE			FREQUENT INDIGESTION		
DIGITALIS TREATMENT			ULCERS		
SHORTNESS OF BREATH			GASTRITIS		
CHEST PAIN			COLITIS		
ASTHMA			PROBLEM CONSTIPATION		
BRONCHITIS			VOMITING BLOOD		
PNEUMONIA			TARRY/BLOODY BOWEL MOVEMENTS		
TUBERCULOSIS			HEMORRHOIDS		
SMOKER'S COUGH			GOITER OR THYROID DISORDER		
EMPHYSEMA			DIABETES		
COUGHING/SPITTING OF BLOOD			SKIN DISORDERS		
HAY FEVER			ARTHRITIS		
MAJOR ALLERGIES			FRACTURE OF NECK OR SPINE		
PALSY OR PARALYSIS			BLEEDING TENDENCY OR DISORDER		
NERVOUS BREAKDOWN			ABNORMAL BLEEDING AFTER TOOTH		
NERVOUS DISORDER			EXTRACTION		

1. DO YOU HAVE AN ALLERGIC REACTION TO ANY MEDICATIONS? \_\_\_\_\_ WHICH? \_\_\_\_\_
2. DO YOU REACT ABNORMALLY TO ANY MEDICATION? \_\_\_\_\_ WHICH? \_\_\_\_\_
3. DO YOU HAVE ANY FAMILY HISTORY OF CANCER/HEART TROUBLE/STROKE? \_\_\_\_\_  
IF SO, WHICH FAMILY MEMBER(S) \_\_\_\_\_
4. DO YOU HAVE COCKTAILS REGULARLY, OR CONSUME REGULAR AMOUNTS OF ALCOHOLIC BEVERAGES, INCLUDING BEER-WINE-OTHER ALCOHOL? \_\_\_\_\_ IF SO, HOW MUCH? \_\_\_\_\_
5. DO YOU SMOKE? \_\_\_\_\_ IF SO, HOW MUCH? \_\_\_\_\_
6. ARE YOU PREGNANT? \_\_\_\_\_ WHEN WAS YOUR LAST MENSTRUAL PERIOD? \_\_\_\_\_
7. AS MOST PROCEDURES ARE DONE UNDER GENERAL ANESTHESIA, MAKING SURE YOU ARE NOT PREGNANT AT THE TIME OF YOUR SURGERY IS A CONCERN TO US. PLEASE INDICATE YOUR CURRENT METHOD OF BIRTH CONTROL:  BIRTH CONTROL PILLS  TUBAL LIGATION  HYSTERECTOMY  IUD  
 PLAN B PILL or RU-486  OTHER: (INCLUDING VASECTOMY) \_\_\_\_\_
8. PLEASE LIST ALL PRESENT MEDICATIONS: INCLUDING BIRTH CONTROL PILLS/PATCH, HORMONES, VITAMINS AND WEIGHT LOSS MEDICATIONS (i.e. MERIDIA, MA HUANG, EPHEDRA, ETC.):  
\_\_\_\_\_  
\_\_\_\_\_
9. HAVE YOU EVER BEEN ON CORTISONE OR STEROID TREATMENT? \_\_\_\_\_ WHEN? \_\_\_\_\_
10. PLEASE LIST ALL SURGICAL PROCEDURES YOU HAVE UNDERGONE:

DATE	PROCEDURE	SURGEON

11. PLEASE LIST HOSPITALIZATIONS:

DATE	HOSPITALIZATION	REASON

12. HOW MANY PREGNANCIES? \_\_\_\_\_ BIRTHS? \_\_\_\_\_ ANY PROBLEMS? \_\_\_\_\_  
PHLEBITIS OR CIRCULATION PROBLEMS? \_\_\_\_\_
13. HAVE YOU EVER BEEN UNDER PSYCHIATRIC CARE? \_\_\_\_\_ WHEN/BY WHOM: \_\_\_\_\_
14. WHEN WAS YOUR LAST PHYSICAL EXAM? \_\_\_\_\_ BY WHOM: \_\_\_\_\_
15. WHEN WAS YOUR LAST EYE EXAM? \_\_\_\_\_ BY WHOM: \_\_\_\_\_
16. WHEN WAS YOUR LAST CHEST X-RAY ? \_\_\_\_\_ BY WHOM: \_\_\_\_\_
17. WHEN WAS YOUR LAST ELECTROCARDIOGRAM (EKG)? \_\_\_\_\_ WHERE? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE

DATE