JOSHUA B. HYMAN, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY

MEDICAL HISTORY

PATIENT'S NAME _____ AGE _____ SEX M F DATE _____

HABITS

	Y	N
1. Are you a smoker?	☐	☐
2. Are you a regular coffee, tea or caffeinated soda drinker?	☐	☐
3. Do you consume alcohol on a regular basis?	☐	☐
4. Do you exercise regularly?	☐	☐

If so, please tell us how much and for how long _____
If you have recently quit, please tell us how long ago _____

PHYSICIANS REGULARLY SEEN

If you under the care of any type of doctor-whether an internist, primary care or specialist- for a current, chronic or long term medical condition, please list doctor's names, phone numbers and area of expertise. If you do not have an internist, please indicate that.

DOCTOR _____ PHONE _____ SPECIALTY _____ DATE LAST SEEN _____

_____

_____

ALLERGIES & SENSITIVITIES

Is there a history of skin or any other untoward reaction or sickness following injection, oral administration or exposure to any of the following? If you answer yes, please explain the nature of reaction/sickness.

	Y	N			Y	N	
A. Penicillin or other antibiotics	☐	☐	_____	H. Morphine, codeine, Demerol or other narcotics	☐	☐	_____
B. Novocaine or other local anesthetics	☐	☐	_____	I. Sodium Pentothal or other anesthetics	☐	☐	_____
C. Sulfa drugs	☐	☐	_____	J. Tetanus antitoxin or other serums	☐	☐	_____
D. Adhesive tape	☐	☐	_____	K. Iodine or Mertiolate, Phisonex or other antiseptics	☐	☐	_____
E. Any other drug or medications	☐	☐	_____	L. Any foods such as eggs, milk or chocolate	☐	☐	_____
F. Latex	☐	☐	_____	M. Surgical tape	☐	☐	_____
G. Inhalers or puffers	☐	☐	_____				

DRUGS RECENTLY TAKEN

Please inform us of any of the following drugs you have taken within the past six months:

	Y	N		Y	N
A. Cortisone/steroids (taken within the past 2 years)	☐	☐	F. Antidepressants (including MAO inhibitors)	☐	☐
B. Anticoagulants (blood thinners)	☐	☐	G. Tranquilizers	☐	☐
C. Hypertensive (high blood pressure medication)	☐	☐	H. Cardiac drugs (Pronestyl, digitalis, etc.)	☐	☐
D. Inderal	☐	☐	I. Accutane (within the past year)	☐	☐
E. Diuretics (water pills)	☐	☐	J. Anti-diabetic drugs	☐	☐

K. Any other prescribed or non-prescribed medications (if none, please write none) _____

L. Any homeopathic, herbal or vitamin preparations (if none, please write none) _____

In the following space, please provide a complete list of all drugs/preparations/ medications which you currently take, including those listed above.

This list is helpful in avoiding possible cross-drug reactions _____

_____

_____

DETAILED MEDICAL HISTORY Do you or a family member have a history of:

	Y	N		Y	N
1. Diabetes	☐	☐	16. High blood pressure	☐	☐
2. Low blood sugar	☐	☐	17. Heart disease (if mitral valve prolapse, please specify)	☐	☐ _____
3. Rheumatic heart disease	☐	☐	18. Heart pacemaker	☐	☐
4. Lung disease	☐	☐	19. Kidney disease	☐	☐
5. Pulmonary embolus	☐	☐	20. Neurological disorders	☐	☐
6. Thyroid, pancreatic or other endocrine disorder	☐	☐	21. Phlebitis	☐	☐
7. Migraine headaches	☐	☐	22. Abnormal bleeding	☐	☐
8. Abnormal clotting	☐	☐	23. Anesthetic problems	☐	☐
9. Cancer (including skin cancer)	☐	☐	24. Coronary surgery	☐	☐
10. Tuberculosis	☐	☐	25. Other serious illness	☐	☐
11. Mitral valve prolapse	☐	☐	26. Anemia	☐	☐
12. Atrial fibrillation	☐	☐	27. Asthma	☐	☐
13. Hepatitis	☐	☐	28. Prostate disorders	☐	☐
14. Acid regurgitation (heartburn)	☐	☐	29. Angina	☐	☐
15. Rheumatic fever	☐	☐	30. Emphysema	☐	☐

ADDITIONAL PERSONAL INFORMATION

	Y	N		Y	N
1. Any weight change in the past 12 months	☐	☐	9. Stomach problems	☐	☐
2. Ulcers	☐	☐	10. Urination problems	☐	☐
3. Other serious illness or medical problems	☐	☐	11. Any previous surgery	☐	☐
4. Ever received a blood transfusion (if Y, what year)	☐	☐	12. Do you use contact lenses	☐	☐
5. Do you wear glasses	☐	☐	13. Do you use dentures	☐	☐
6. Do you use a hearing aid	☐	☐	14. Do you form keloids	☐	☐
7. Do you form thick, red or raised scars	☐	☐	15. Do you have any thick, red or raised keloid	☐	☐
8. Have you ever undergone scar revisions or treatment scars on your body for improving scarring	☐	☐			

Female patients only

16. Number of pregnancies _____ Number of children _____ Did you breast feed _____ Last menstrual cycle _____

BLEEDING PROFILE

	Y	N
1. Do you have any problems with bleeding in general	☐	☐
a. after a razor cut	Y	N
b. after a tooth extraction	Y	N
c. after previous surgery	Y	N
d. after a delivery	Y	N
2. Do you bruise easily or remain bruised for long periods of time	☐	☐
3. Have you ever received blood transfusions or blood products (plasma, platelets, etc.)	☐	☐
4. Is there a family history of bleeding problems	☐	☐
5. Do you use aspirin regularly	☐	☐
6. NSAIDS such as Advil, Motrin, Ibuprofen,Aleve, Naproxen, etc.	☐	☐
7. Do you take Vitamin E	☐	☐
8. Do you take blood thinners	☐	☐

Please indicate whether or not you regularly use the following drugs which contain aspirin

	Y	N		Y	N		Y	N		Y	N
Darvon	☐	☐	Empirin	☐	☐	Midol	☐	☐	Alka Seltzer	☐	☐
Percodan	☐	☐	Alka Seltzer Plus	☐	☐	Fluorinal	☐	☐	Coricidin	☐	☐
Bufferin	☐	☐	Excedrin	☐	☐	Ascriptin	☐	☐			

Please see separate list of foods and drugs known to cause bleeding and any you take regularly. Also please list any other foods or drugs that make you bruise easily _____

PREVIOUS PERSONAL & FAMILY HISTORY

	Y	N
1. Have you had previous surgery? _____	☐	☐

2. If so, please indicate the type of anesthesia used as well as any complications or reactions you experienced:

- ☐ Local anesthesia _____
- ☐ General anesthesia _____
- ☐ Spinal anesthesia _____
- ☐ Sedation _____

3. Have there been unexpected deaths or complications from anesthesia (including in the dental office) in any members of your family?	☐	☐
4. Is there a personal or family history of unexplained high fevers (known as malignant hyperthermia) following drug administration or general anesthesia? _____	☐	☐
5. Is there a personal or family history of dark or cola-colored urine following anesthesia?	☐	☐
6. Is there a personal or family history of masseter muscle rigidity (MMR)? (This is a severe, sustained contracture of the jawbone muscle)	☐	☐

7. Do you have a personal or family history of the following:

a. scoliosis or kyphosis (hunched back)	Y N	d. muscle disorder	Y N
b. spontaneous muscle cramps	Y N	e. squint	Y N
c. any other problems with muscle function	Y N		

SIGNATURE _____ **DATE** _____

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