Oslin Plastic Surgery, P.L.L.C.
Medical History Form

NAME:____

DRUG ALLERGIES: _________________________________

Height: _______________ Weight: _____________

Date of Last Physical Examination: ____/____/____
by Dr. ____
Date of Last Mammogram: ____/____/____
Medications: ____
____
____
____

Personal History of: (please check)

___diabetes	___high blood pr	___heart disease
___kidney failure	___asthma	___pneumonia
___emphysema	___lung disease	___thyroid disorder
___heart attack	___irreg. heartbeat	___stomach ulcers
___hepatitis	___seizures	___stroke
___depression	___alcohol abuse	___blood transf.
___drug abuse		___unexplained wt. loss
___cancer (please specify type)		
___MRSA infection		

Family History of any the above? Specify:
____
____

Tobacco history:

do you smoke presently? _______ how much? ______________
if not presently, when did you stop? ______________________

Surgical History:
Have you had any operations? (PLEASE LIST)______________
____
____

Exercise History:
How often do you exercise?_________________________________
What type?____
Is your weight stable?______________________________________