

Osl in 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)

- | | | |
|---|---|--|
| <input type="checkbox"/> diabetes | <input type="checkbox"/> high blood pr. | <input type="checkbox"/> heart disease |
| <input type="checkbox"/> kidney failure | <input type="checkbox"/> asthma | <input type="checkbox"/> pneumonia |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> lung disease | <input type="checkbox"/> thyroid disorder |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> irreg. heartbeat | <input type="checkbox"/> stomach ulcers |
| <input type="checkbox"/> hepatitis | <input type="checkbox"/> seizures | <input type="checkbox"/> stroke |
| <input type="checkbox"/> depression | <input type="checkbox"/> vision problems | <input type="checkbox"/> blood transf. |
| <input type="checkbox"/> drug abuse | <input type="checkbox"/> alcohol abuse | <input type="checkbox"/> unexplained
wt. loss |
| <input type="checkbox"/> cancer (please specify type) | | |

Family History of any the above? specify

Tobacco history: cigarettes cigars chewing tobacco
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? _____