NEW ENGLAND
PLASTIC SURGERY CENTER
LOREEN ALI MD

Patient Label

# Medical History Form

Name:____________________________________________________Date of Birth: _____/_____/_____ Age_________
First Middle Last

Referring Provider: __________________________ Primary Care physician: ______________________________

Your Pharmacy: Name: _______________________
Address: ____________________________________ City, State: _____________________

**Chief Complaint:**
What is the main reason for your visit? _______________________________________

**Medical History:** **Your Height** __________________ **Your Weight** _________________

| | Yes | No | Comments |
|---|---|---|---|
| **Heart Disease** | | | |
| **Diabetes** | | | |
| **High Blood Pressure** | | | |
| **History of Heart Attack** | | | |
| **Asthma or Emphysema** | | | |
| **Back Problems** | | | |
| **History of Stroke** | | | |
| **Breast cancer** | | | |

***Have you ever had any of the following?***

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| **AIDS/HIV** | | | **Depression** | | | **Poor healing** | | |
| **Anemia** | | | **Diabetes** | | | **Rheumatic Fever** | | |
| **Anxiety** | | | **Glaucoma** | | | **Skin Cancer including Melanoma** | | |
| **Arthritis** | | | **Heart Disease** | | | **Stents** | | |
| **Asthma** | | | **Heart murmur** | | | **Stomach ulcers** | | |
| **Atrial fibrillation** | | | **Hepatitis** | | | **Stroke** | | |
| **Bleeding problems** | | | **High Blood Pressure** | | | **Thyroid Disease** | | |
| **Blood Clots/Embolism** | | | **Kidney Disease** | | | **Breast Biopsies** | | |
| **Cancer** | | | **Pacemaker/Defibrillator** | | | **Significant weight loss/gain** | | |

**Surgical History (PROCEDURES):**

| | Please List Surgeries and Dates | | |
|---|---|---|---|
| **1** | | **3** | |
| **2** | | **4** | |

**Medications:**
**Circle applicable: Aspirin Plavix Coumadin/Warfarin Eliquis Xarelto Pradaxa**

| | List all prescriptions and over the counter medications **with doses** | | |
|---|---|---|---|
| **1** | | **4** | |
| **2** | | **5** | |
| **3** | | **6** | |

Patient Label

**Allergies to Medications and/or Food:**

| Medication | Reaction | Medication | Reaction |
|---|---|---|---|
| | | | |
| | | | |

**Family History**: (Please note if this relates to you or a family member)

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Breast Cancer | | | Skin Cancer | | | Diabetes | | |
| Heart Disease | | | Melanoma | | | Kidney Disease | | |

**Review of Systems:**
(If you h*ave you experienced these symptoms within the last 30 days, please circle)*

| | | | | | |
|---|---|---|---|---|---|
| **General** | anemia | fevers | night-sweats | weight-loss | swollen glands |
| **Breast** | lumps | discharge | pain | | |
| **Ears** | ringing | hearing loss | infections | | |
| **Eyes** | blurring | double vision | cataracts | glaucoma | |
| **Nose/Sinus** | infections | bleeding | | | |
| **Throat** | infections | hoarseness | trouble swallowing | | |
| **Endocrine** | thyroid problems | cold intolerance | heat intolerance | | |
| **Lungs** | cough | phlegm | coughing up blood | short of breath | |
| **Heart** | chest pain | palpitations | ankle swelling | | |
| **Vascular** | leg cramps | varicose veins | phlebitis | blood clots | |
| **Gastro** | nausea | vomiting | diarrhea | constipation | change in bowels |
| **Gastro (con't)** | hemorrhoids | hepatitis | | | |
| **Skin** | rash | easy bruising | poor healing | itching | Changing mole |
| **Urinary** | frequency | burning urination | blood urine | kidney stones | infections |
| **Bone/Joint** | pain | stiffness | swelling | limited motion | |
| **Nervous Sys** | seizures | tremors | Fainting/ black-outs | numbness | weakness |
| **Nervous (con't)** | dizziness | trouble speaking | anxiety | depression | |

**Please answer the following questions:**

Do you have any Dermal Piercings: (circle) No Yes if yes: location ___________ metal or plastic?

Last menstrual cycle: (if applicable) _______________

Have you ever had an allergy to contrast dye (circle) Yes No n/a

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## Social History:

Occupation: _________________________ Employer: ____________________________________

Marital Status: S M D W # of Children/ages of Children ________________________________

## Preventative Screening:

| **Alcohol Screening** | # Glasses of Wine | # Cans of Beer | # Shots of Liquor |
|---|---|---|---|
| How many drinks per week? | | | |
| **Smoking Status (circle)** | Never | Currently Smoking | Former Smoker |
| | | How many Packs per day: | Date: Quit |

I verify that the above information is true and accurate to the best of my knowledge. I consent to the use of my records and photographs for treatment, educational, credentialing and laboratory testing purposes.

Patient signature: ____________________________________________ Date: ______________________

If form filled out by someone other than patient, list relationship to patient: ______________________________

This form was reviewed by MD with patient at time of consultation: _______________
(physician initials)

Form date 11/29/19