NORTH BEACH
PLASTIC SURGERY

Patient Name _____ Date _____

Medical History

	Vitals	
Weight (lbs)		
Height (inches)		
BMI (office use only)		
Temperature		
O2		
BP		

		Details
CARDIOVASCULAR		
High Blood Pressure	☐	
Defirillator or Pacemaker	☐	
Heart Attack of failure	☐	
Heart Disease	☐	
Irregular heartbeat/arrhythmia	☐	
RESPIRATORY		
Asthma	☐	
COPD/Emphysema	☐	
Sleep Apnea	☐	
Shortness of breath	☐	
GASTROINTESTINAL		
Hepatitis	☐	
Liver Disease	☐	
Hernia	☐	
Ulcers	☐	

SKIN		**Details**
Keloids or poor scarring	☐	
Skin Cancer	☐	
Previous radiation therapy	☐	
ENDOCRINE		
Diabetes	☐	
Thyroid Disorder	☐	
HEMATOLOGIC/ONCOLOGIC		
Blood clots/Bleeding Disorder	☐	
Bleeding Problems	☐	
Easy bruising	☐	
HIV	☐	
Cancer	☐	
Anemia	☐	
NEUROLOGIC		
Stroke	☐	
Seizures	☐	
Neurologic Disease	☐	
EYES		
Dry Eyes	☐	
Glaucoma	☐	
PSYCHIATRIC		
Depression/Anxiety	☐	
Other psychiatric conditions	☐	
FOR WOMEN ONLY		
Mammogram in the last year	☐	
Attempting or currently pregnant	☐	
Breastfeeding	☐	
# of childbirths		
OTHER		
Kidney problems	☐	
MRSA	☐	
Artificial Joints/Implants	☐	
Other relevant medical history	☐	

Patient Past Surgeries/Hospitalizations

		Details
SURGICAL HISTORY		
Past Surgeries	☐	
Problems with Anesthesia	☐	
Malignant Hyperthermia	☐	

OB/GYN HISTORY		Details
Hysterectomy	☐	
C-section	☐	
COSMETIC HISTORY		
Cosmetic Surgeries	☐	
Botox/Dysport	☐	
Fillers	☐	
Lasers/Chemical Peels	☐	
Microneedling	☐	

Relevant Family History

		Afflicted Family Member	Details
Autoimmune Disorders	☐		
Breast Cancer	☐		
Heart Disease	☐		
Keloids/Poor Scarring	☐		
Hemophilia	☐		
Melanoma	☐		
Other Skin Cancer	☐		
Unknown	☐		
Other relevant family history	☐		

Social History

TOBACCO HISTORY		Details
No recent history of tobacco/nicotine use	☐	
Cigarettes, cigars, or pipes (if yes, how often?)	☐	
Vapes (if yes, how often?)	☐	
Nicotine patches or gum (if yes, how often?)	☐	
Chewing tobacco (if yes, how often?)	☐	
ALCOHOL/RECREATIONAL DRUG USE		**Comments**
No alcohol use	☐	
1-4 drinks/week	☐	
5-10 drinks/week	☐	
More than 11 drinks/week	☐	
No use of recreational drugs	☐	
Currently or recently used drugs	☐	
No marijuana use	☐	
Current or recent marijuana use	☐	

Patient Allergies

		Allergy	Reaction
None	☐		
1	☐		
2	☐		
3	☐		
4	☐		
5	☐		
6	☐		

Current Prescription & Over-the-counter Medications and Supplements

		Medication/dosage	Frequency	Notes
None	☐			
1	☐			
2	☐			
3	☐			
4	☐			
5	☐			
6	☐			
7	☐			
8	☐			
9	☐			
10	☐			

Additional medication questions:	Yes	No	Notes
Are you taking aspirin or any other blood thinning medication?	☐	☐	

Medical History Verification: All information provided above is accurate and complete to the best of my knowledge.

Patient initials (or Guardian): _____

Patient signature: _____

Date: _____