EASTERN VIRGINIA MEDICAL SCHOOL
Established 1973

PLASTIC AND COSMETIC SURGERY CENTER OF EVMS

Division of Plastic Surgery
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MEDICAL HISTORY

Date: _____

Please answer all the following questions. The information provided will be kept confidential and will better assist your doctor in making decisions regarding your care.

Name: _____ Age: _____ HT: _____ WT: _____

Primary Care Physician and/or Specialist: _____

Allergies to medications: _____

Do you have or have you ever had the following:

Asthma/Bronchitis	*Yes*	No	Arthritis	Yes	No	Hepatitis/Tuberculosis	Yes	No
Bleeding Problems	Yes	No	Diabetes	Yes	No	Hypertension	Yes	No
Cardiac Problems	Yes	No	Epilepsy	Yes	No	Hypoglycemia	Yes	No
Dizziness/Fainting	Yes	No	Emphysema	Yes	No	Thyroid Problems	Yes	No
Heart Attack/Stroke	Yes	No	Headaches	Yes	No	Tested Positive HIV/Aids	Yes	No
Mitral Valve Prolapse	Yes	No	Hearing Loss	Yes	No	Received Blood Transfusion	Yes	No

Explanation for any "yes" answers above: _____

_____

_____

Do you have to take an antibiotic before any dental work? Yes / No

Smoke? Yes / No
How much? _____

Alcohol? Yes / No
How much? _____

List any surgical procedures you have had in the past: _____

_____

_____

List ALL medications you are currently taking (including vitamins): _____

_____

_____