Paul M. Figlia, MD, PA
Board Certified Plastic & Reconstructive Surgeon

PATIENT MEDICAL HISTORY FORM

Patient Name _____ Today's Date _____

Primary Care Physician's Name _____ Tel. No. _____

Address _____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THESE CONDITIONS? (Please check)

__ Diabetes	__ Heart Murmur	__ Crohn's Disease
__ High Blood Pressure	__ Pneumonia	__ Colitis
__ High Cholesterol	__ Pulmonary Embolism	__ Anemia
__ Hypothyroidism	__ Asthma	__ Jaundice
__ Goiter	__ Emphysema	__ Hepatitis
__ *Cancer	__ Stroke	__ Stomach or Peptic Ulcer
__ Leukemia	__ Epilepsy (Seizures)	__ Rheumatic Fever
__ Psoriasis	__ Cataracts	__ Tuberculosis
__ Angina	__ Kidney Disease	__ HIV/AIDS
__ Heart Problems	__ Kidney Stones	__ Other

*Type of Cancer (if applicable) _____

SURGICAL HISTORY

Type of Surgery(s) and Dates

_____

_____

_____

_____

MEDICATIONS (Please provide the following information for ALL of your medications)

Dosage and Name of Rx or Over the Counter Drugs including Vitamins/Supplements

_____

_____

FEMALE PATIENTS (Please complete the following)

Name of Gynecologist _____ Tel. No._____

Gynecologist's Address _____

Have you ever been pregnant: Y or N
Number of Pregnancies_____
Number of Vaginal Deliveries_____
Number of Cesarean Sections _____

Have you ever had a Mammogram? Y or N
Were there abnormal findings: Y or N
Date of Last Mammogram _____
Where was it performed? _____

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PATIENT MEDICAL HISTORY FORM

Do you take ASPIRIN, or products containing aspirin? Y or N

ALLERGIES

Are you allergic to ANY medications? Y or N

Any other known allergies Y or N

NAME OF ALLERGY	SYMPTOMS OF ALLERGIC REACTION

SUBSTANCE USE	HOW OFTEN?	WHEN LAST USED?	CURRENTLY USING
__ Alcohol			
__ Nicotine			
__ AMPHETAMINES/OTHER STIMULANTS (Ritalin, Benzedrine, Dexedrine			
__ BENZODIAZEPINES/TRANQUILIZERS (Valium, Librium, Halcion, Xanax, Diazepam, "Roofies")			
__SEDATIVES/HYPNOTICS/BARBITURATES (Amytal, Seconal, Dalmane, Quaalude, Phenobarbital			
__ OTHER OPIOIDS (Tylenol #2 & #2, 292'S, 292'S Percodan, Percocet, Opium Morphine, Demerol, Dilaudid)			
__ CANNABIS (Marijuana, hashish, hash oil)			
__ OTHER (Please explain)			

ALL PATIENTS, PLEASE READ CAREFULLY:

I verify that the above information is correct to the best of my knowledge. I will not hold Dr. Figlia or members of his staff responsible for any errors or omissions I may have made in the completion of this form.

Patient or Responsible Party's Signature _____Date _____