WETHERINGTON
PLASTIC SURGERY CENTER

Name:_____ **D.O.B.** _____ **Age:** _____ **Height:** _____ **Weight:** _____

Referring Physician: _____**Primary Care Physician:** _____

If not referred by a Physician, how were you referred to the practice? _____

What will you be seeing the doctor for today? _____

MEDICAL INFORMATION

	SELF	FAMILY		SELF	FAMILY
Diabetes	No Yes	No Yes	**G/Esophogeal Reflux**	No Yes	No Yes
Hypertension	No Yes	No Yes	**Bleeding Tendency**	No Yes	No Yes
Cancer	No Yes	No Yes	**Ulcer Disease**	No Yes	No Yes
Stroke	No Yes	No Yes	**Kidney Disease**	No Yes	No Yes
Heart Trouble	No Yes	No Yes	**Anemia**	No Yes	No Yes
Lung Disease	No Yes	No Yes	**Tuberculosis**	No Yes	No Yes
Seizures	No Yes	No Yes	**Anxiety/Depression**	No Yes	No Yes
Arthritis	No Yes	No Yes	**Skin Cancer**	No Yes	No Yes
Asthma	No Yes	No Yes	**Sleep Apnea**	No Yes	No Yes

Please list any previous hospitalizations/surgeries/serious injuries: _____
_____
_____

Please list all current medications: _____
_____
_____

Are you allergic to any medications? Please list and include what reactions you have if taken: _____
_____
_____

Do you smoke? _____ **If yes, how much?** _____

Do you use alcohol? _____ **If yes, how much?** _____

Are you married, single, widowed, divorced, or separated? _____

PATIENT'S SIGNATURE: _____ **DATE:** _____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____