

Sharma Plastic Surgery

12640 Creekside Lane ~ Fort Myers, Florida ~ 33919

Phone (239) 482-7676 ~ Fax (239) 482-7604

Patient Health History

NAME: _____

Date: _____
Date of Birth: _____

HEIGHT: _____

WEIGHT: _____

MEDICATIONS: List all current medications including non-prescription drugs, herbs, and supplements. If you have a separate list of medications please provide the front desk with the list and print "see list" below in the first box.

Name	Strength	Frequency	Name	Strength	Frequency
1. _____			5. _____		
2. _____			6. _____		
3. _____			7. _____		
4. _____			8. _____		

ALLERGIES: (Please List Allergy and Reaction)

NO ALLERGIES

PATIENT CURRENT / PAST MEDICAL HISTORY:

	YES	NO		YES	NO		YES	NO		YES	NO
Alcohol/Drug Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fever/Blisters Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hereditary Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever experienced bleeding tendencies? Yes No

Are you currently under psychiatric care? Yes No

Do you have a psychiatric diagnosis? Yes No If Yes, please explain _____

Have you ever or are you currently taking medications for a psychiatric diagnosis? _____

Are you currently taking a diuretic medication Yes No If yes please list name: _____

Have you ever experienced or been diagnosed with sleep apnea? Yes No

Date of last mammogram (if applicable) _____

ADDITIONAL MEDICAL PROBLEMS / PREVIOUS HOSPITALIZATIONS / SURGERIES / SERIOUS INJURIES:

1. _____ Date: _____ 4. _____ Date: _____

2. _____ Date: _____ 5. _____ Date: _____

3. _____ Date: _____ 6. _____ Date: _____

SOCIAL HISTORY:

Do you currently use nicotine products (vape, gum, patches, smoke, etc.):

No Yes (if yes, packs/day) _____ Years _____ Packs/Day

Did you smoke in the past?

No Yes (when stopped) _____

Do you use recreational drugs?

(This includes medical marijuana/vaporized marijuana)

No Yes (Please list types): _____

Do you drink alcohol:

No Yes (if yes, amount/week) _____

Do you drink caffeine:

No Yes (if yes, list amount) _____

FAMILY MEDICAL HISTORY (Immediate family only):

Family Member: _____ Dx: _____ Family Member: _____ Dx: _____

Family Member: _____ Dx: _____ Family Member: _____ Dx: _____

Family Member: _____ Dx: _____ Family Member: _____ Dx: _____

Primary Care Physician:

Name: _____ Phone Number: _____

Cardiologist:

Name: _____ Phone Number: _____

Malignant Hyperthermia Risk Screening

Please check of the following that apply to you:

1. Do you have a family history of unexpected death(s) following general anesthesia or exercise?

Yes No

2. Do you have a family OR personal history of Malignant Hyperthermia, a muscle or neuromuscular disorder, high temperature following exercise?

Yes No

3. Do you have a personal history of muscle spasm, dark or chocolate-colored urine?

Yes No

4. Do you have personal history of unanticipated fever immediately following anesthesia or serious exercise?

Yes No

Signature: _____ **Date:** _____