AESTHETIC AND RECONSTRUCTIVE SURGERY

LEXINGTON PLASTIC SURGERY
A Lexington Medical Center Physician Practice

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LexPlasticSurgery.com

Lexington Medical Center

Patient History

Name:_____ Date of Birth:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Are there any restrictions for contacting you? ☐ Yes ☐ No If yes, contact restrictions:_____

_____

Do you give us permission to leave a message on answering machine? ☐ Yes ☐ No Occupation:_____

Local Pharmacy: _____

TODAY'S VISIT

What brings you to see us?

How did you hear about Dr. Lefkowitz/Lexington Plastic Surgery?

MEDICAL/SURGICAL HISTORY

PERSONAL MEDICAL HISTORY: Please list any medical conditions for which you are/have been treated (include any hospitalizations and surgeries)

	TYPE OF CONDITION/HOSPITALIZATION/SURGERY	DATES TREATED
1		
2		
3		
4		
5		

NON-SURGICAL COSMETIC PROCEDURES:
Please list any non-surgical cosmetic procedures you have had and where. (E.g. Botox – forehead; Chemical peel – face; Fillers – face)

GYNECOLOGICAL/WOMEN'S HEALTH:

Number of Pregnancies:	C-Sections:	Miscarriages/Spontaneous Abortions:
Year of Last Pregnancy:	Do you currently or have you ever breast fed? ☐ Yes ☐ No	
Are you on birth control? ☐ Yes ☐ No If yes, list type/brand of birth control:		

SOCIAL HISTORY:

Do you smoke, vape, use tobacco or marajuana? ☐ Yes ☐ No	Quit how long ago:	Do you use the nicotine patch or gum? ☐ Yes ☐ No
Recent weight change? ☐ Yes ☐ No If yes, ☐ Increase (up) ☐ decrease (down) How much?		

CONTINUED ON BACK

REVIEW OF SYSTEMS:

Please answer the following yes/no questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

HEMATOLOGIC/ONCOLOGIC	Yes	No
Breast Disease		
Bleeding Tendency		
Easy Bruising		
Anemia		
Sickle Cell Disease		
Blood Clots in Legs		
Blood Clots in Lungs		
Radiation Therapy		

CARDIOVASCULAR	Yes	No
High Blood Pressure		
Heart Attack		
Angina/Chest Pain		
Heart Bypass Surgery		
Pacemaker		
Heart Failure		
Irregular Heartbeat		
Do you exercise? Comments:		

MUSCULOSKELETAL	Yes	No
Herniated Disk (neck, back)		
Arthritis		
Rheumatoid Arthritis		

INFECTIOUS/GASTROINTESTINAL	Yes	No
Hepatitis		
HIV/Aids		

SKIN	Yes	No
Staph Infection		
Problems with Scarring (E.g. keloids, widened, etc.)		

ENDOCRINE	Yes	No
Diabetes		
Thyroid Disease		
Taken Steroids		

NEUROLOGICAL	Yes	No
Stroke		
Seizures		
Depression		
Bi-Polar		

ALLERGIES/REACTIONS:

PLEASE ANSWER THE FOLLOWING YES/NO QUESTIONS TO THE BEST OF YOUR ABILITY.	Yes	No
Do you have any allergic or unusual reactions to medications, anesthesia, or other substances (e.g. latex)? If yes, please list:		
Do you experience cold sores or fever blisters?		

MEDICATIONS: Please list all medications you take presently and within the last six months.

	MEDICATION NAME	DOSAGE IN MILLIGRAMS OR GRAMS	FREQUENCY (E.G. ONCE A DAY)
1			
2			
3			
4			
5			

HERBAL/SUPPLEMENTS/VITAMINS:

List any herbal supplements you are taking (e.g. Ginko, Ginger, Garlic, St. John's Wort, Saw Palmetto, Flax Seed, etc.): _____

_____

List any vitamins (e.g. Vitamin C, E, Fish Oils) you are taking: _____

Signature_____ Date:_____