Steven M. Zoellner, M.D.
PINEHURST PLASTIC SURGERY SPECIALISTS

Patient History Form

Patient Name_____ Date of Birth_____

Reason for Consultation_____

Medical Physician_____Referring Physician_____

Height_____ & Weight_____ *If any weight loss or gain or loss please specify amount and over what time frame*_____

What is your current exercise regimen_____

Please Circle Yes or No and What Condition Applies To You

Yes No High Blood Pressure, Stroke

Yes No Heart Attack, Pacemaker, Irregular Heartbeat, Chest Pain, Congestive Heart Failure, Circulatory Problems, Mitral Valve Prolapse

Yes No Asthma, COPD, Emphysema, Shortness of Breath, Sleep Apnea

Yes No Have you had a Sleep Study and if so do use CPAP at night_____

Yes No Diabetes, Kidney Failure

Yes No Back or Neck Pain, Arthritis

Yes No Hepatitis, Jaundice, AIDS, HIV, Immunosuppressive Disorders

Yes No History of Blood Clots, Blood Disease, Bleeding Problems

Yes No Epilepsy, Sinus Problems, Headaches/Migraines

Yes No History of Cancer – If Yes, List Type & When_____

Yes No Anxiety, Depression, Chemical Dependency and/or under Psychiatric Care

Yes No Gastrointestinal Disorders, Ulcers, Chronic Diarrhea

Yes No Do you currently use or have used in the past any tobacco or nicotine products

Yes No Do you consume alcoholic beverages

Yes No Do you use illicit drugs

Yes No Have you been instructed to take an antibiotic prior to dental work or surgical procedure.

Yes No Do you have any significant family history that we should be aware of:

_____

Yes No Is there anything else we should know about your medical history:_____

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Women Only

Last Menstrual Cycle_____ Number of Pregnancies_____

Number of children and ages_____ Planning Future Pregnancy_____

Allergies

(including both prescribed, over the counter, latex and betadine etc.)

_____ _____ _____ _____

Current Medications

(including both prescribed and over the counter, including herbal)

_____ _____ _____ _____

_____ _____ _____ _____

Past Surgical Procedures

_____ _____ _____ _____

Breast Augmentation & Mastopexy (Breast Lift) Consults Only

What is your current bra size_____ What is your desired bra size_____

Yes No Did you breastfeed and if so length of time_____

Yes No Have you ever had a mammogram performed. If yes, when_____

Yes No Have you ever had any breast problems (lumps, cancer, biopsies, abnormal mammogram) If yes please list type and when_____

Yes No Do you have any family history of breast cancer or breast problems. If yes please list type and relationship to family member_____

The above information is accurate and complete to the best of my knowledge

Patient/Responsible Adult Signature _____ *Date*_____

*Reviewed by Clinical Staff*_____ *Date*_____

Reviewed by Physician _____ *Date* _____