

M. AZHAR ALI, MD FACS
PLASTIC AND RECONSTRUCTIVE SURGERY
PATIENT HEALTH HISTORY

Date: _____ Name: _____

Age: _____ Height: _____ Weight: _____ Reason for visit: _____

Illness:

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation/Chemotherapy | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | _____ |
| | | _____ |
| | | _____ |

Previous Surgeries:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Medications: (if you need more space, please continue on back of paper)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Allergies:

Drug: _____

Food: _____ Dyes: _____

Social History:

Do you/the patient smoke? _____ If yes, how much? _____

Do you/the patient consume alcohol? _____ If yes, how much? _____

Do you/the patient use illegal drugs? _____ If yes, how much and what? _____

I certify that the above information is true.

Patient/Guardian Signature: _____ Date: _____