

RONALD M. FRIEDMAN, M.D., P.A.

Cosmetic and Reconstructive Plastic Surgery · Hand Surgery and Microsurgery

BOARD CERTIFIED, AMERICAN BOARD OF PLASTIC SURGERY

Health History



MEMBER OF THE AMERICAN SOCIETY OF PLASTIC SURGEONS



MEMBER OF THE AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY

Date: _____ Name of person completing form (if different from patient) _____

1. Name: _____ Age: _____ Sex: M / F

2. Occupation: _____ Height: _____ Weight: _____

3. Primary medical/cosmetic complaint: _____

4. Who is your regular physician? _____

Physician's address and phone number: _____

5. Whom may we thank for referring you to our office?

Doctor (name) _____ Family Member _____

Friend (name) _____ Advertisement (Where?) _____

Internet (name of site) _____ Other (please list) _____

6. How is your general health? ___ Excellent ___ Good ___ Fair ___ Poor

7. Have **YOU** ever had any of the following illnesses? Please circle Yes or No. If yes, please state the date. Please check v if an immediate family member has had one of these illnesses.

	<u>YOU</u>	<u>Date</u>	<u>v Family Member</u>
Diabetes	Yes No	_____	_____
High blood pressure	Yes No	_____	_____
Chest pain	Yes No	_____	_____
Heart disease	Yes No	_____	_____
Sleep apnea	Yes No	_____	_____
Shortness of breath	Yes No	_____	_____
Asthma	Yes No	_____	_____
Stroke	Yes No	_____	_____
Cancer	Yes No	_____	_____
Seizures, epilepsy	Yes No	_____	_____
Hepatitis, jaundice	Yes No	_____	_____
Arthritis	Yes No	_____	_____
Stomach ulcer	Yes No	_____	_____
Anemia	Yes No	_____	_____
Bleeding disorder	Yes No	_____	_____
Depression	Yes No	_____	_____
Nervous breakdown	Yes No	_____	_____
Thyroid disorder	Yes No	_____	_____
Glaucoma	Yes No	_____	_____
Kidney disease	Yes No	_____	_____

8. Please list ANY other medical problems: _____

CONTINUED ON OTHER SIDE

Plano and Flower Mound

Tel 469.467.0100 · Fax 469.467.0105 · www.plasticsurgerydallas.com

05/09

Ronald M. Friedman, M.D., P.A.

Health History

9. Please list all prior surgeries and dates: _____

10. Please list all current medications (including dosages):

Medication	Dosage	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

11. Please list any drug allergies: _____

Do you have allergies to: (please circle if applicable) adhesives, tape, bandaids, latex, gloves

12. Do you smoke? Yes No

If yes, how many packs per day? _____ How many years? _____

If no, have you ever been a smoker? Yes No When did you quit? _____

13. Do you drink alcohol? _____ No _____ Occasionally _____ Weekly _____ Daily

14. Do you exercise? _____ No _____ Occasionally _____ Weekly _____ Daily

15. Do you take aspirin / ibuprofen regularly? Yes No

16. Do you bleed easily? Yes No

17. Do you form unsightly scars? Yes No

18. Are you under any excessive emotional distress? Yes No

If yes, please explain: _____

19. Have you had any recent weight changes? Yes No

If yes, please explain: _____

20. In the past year, have you had any of the following?

Complete physical exam	Yes	No
Blood tests	Yes	No
Chest x-ray	Yes	No
Mammogram	Yes	No
EKG	Yes	No

21. What are your hobbies? _____

Thank you for taking the time to complete this form thoroughly. Your accurate responses will help us to better serve your health care needs.