



LONG ISLAND PLASTIC SURGICAL GROUP, P.C.
PATIENT HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Reason for today's visit: _____

Are you currently under the care of or have you ever been treated by a Medical Physician for any significant illness other than colds, flu or virus? If so, please explain:

Table with 4 columns: Condition, No, Yes, and If YES, please explain. Rows include Cardiac History, Diabetes, Asthma, Hepatitis, Sleep Apnea, Bleeding Problems, and Hypertension.

Have you had any surgical procedures in the past?

Table with 4 columns: Date (mm/yy), Type of Surgery, Name of Doctor, and Hospital. Includes three rows for data entry.

Do you have any allergies to Medications?

Table with 4 columns: Medication, Yes, No, and If YES, please specify. Rows include Penicillin, Local Anesthesia, General Anesthesia, and Any others.

Do you have any bleeding tendencies?

Yes No

What antibiotics have you tolerated?

Are you presently taking any medications?

Table with 3 columns: Medication, Yes, No. Rows include Aspirin, Oral Contraceptives, and Blood Thinners.

Any Others including Over the Counter Medications and Herbal Remedies:

If Yes, please specify below:

Table with 3 columns: Name of Medication, Dosage, and Frequency. Includes three rows for data entry.

Do you smoke cigarettes? Yes No If yes, how many packs per day?_____

PCP Name, Address & Phone Number: _____

Who can we thank for referring you to our practice? _____

*** If you are using any controlled substance, please bring this to your doctor's attention. ***