

MADISON PLASTIC SURGERY, P.C.

Plastic & Reconstructive Surgery

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Patient History Form

Social

Age: _____ Sex: M F Married: Y N Occupation: _____

Is a responsible adult available to assist during recovery period? Y N Relationship: _____

Habits

Smoker Y N Amount _____

Coffee/Tea/Cola: Y N Amount _____

Alcohol Y N Amount _____

Daily Exercise Y N Amount _____

Medications

List medications and number of pills per day:

Prescription:

Non-Prescription (Vitamins, Herbs):

Regular aspirin use: Y N

Dosage & frequency: _____

Advil, Motrin, Ibuprofen Y N

Dosage & frequency: _____

Cortisone injection in past year Y N

Date(s) and injection locations: _____

Drug allergy Y N

List drug(s) and type of reaction: _____

Purifiers, inhalers Y N

Latex allergy Y N

Tape allergy Y N

Family History:

Have any of your blood relations ever had the following problems:

Abnormal breathing: Y N

Coronary surgery: Y N

Kidney disease: Y N

Abnormal clotting: Y N

Diabetes: Y N

Tuberculosis: Y N

Anesthetic problems: Y N

Heart attack: Y N

Other serious illness: Y N

Cancer: Y N

Hypertension Y N

Please describe the items from the list above for which you answered "Y" :

Personal History

Have you ever had any of the following problems:

Abnormal breathing:	Y <input type="checkbox"/> N <input type="checkbox"/>	Asthma:	Y <input type="checkbox"/> N <input type="checkbox"/>	Heart attack:	Y <input type="checkbox"/> N <input type="checkbox"/>
Abnormal clotting:	Y <input type="checkbox"/> N <input type="checkbox"/>	Atrial Fibrillation:	Y <input type="checkbox"/> N <input type="checkbox"/>	Hepatitis:	Y <input type="checkbox"/> N <input type="checkbox"/>
Acid regurgitation	Y <input type="checkbox"/> N <input type="checkbox"/>	Diabetes:	Y <input type="checkbox"/> N <input type="checkbox"/>	Hypertension:	Y <input type="checkbox"/> N <input type="checkbox"/>
Anemia:	Y <input type="checkbox"/> N <input type="checkbox"/>	Fainting spell:	Y <input type="checkbox"/> N <input type="checkbox"/>	Mitral valve prolapse:	Y <input type="checkbox"/> N <input type="checkbox"/>
Angina:	Y <input type="checkbox"/> N <input type="checkbox"/>	Prostate disorders:	Y <input type="checkbox"/> N <input type="checkbox"/>	Skin conditions:	Y <input type="checkbox"/> N <input type="checkbox"/>
Urination problems:	Y <input type="checkbox"/> N <input type="checkbox"/>	Weight change in past 12 months	Y <input type="checkbox"/> N <input type="checkbox"/>		
Stomach problems:	Y <input type="checkbox"/> N <input type="checkbox"/>	Other serious illness:	Y <input type="checkbox"/> N <input type="checkbox"/>		
Ulcers:	Y <input type="checkbox"/> N <input type="checkbox"/>				

Please describe the items from the list above for which you answered "Y" :

Have you ever received a transfusion? Y N If yes, in what year? _____

Have you been tested for HIV? Y N If yes, in what year? _____

Test results: Positive Negative

Do you wear any of the following? Contact lenses Y N Eyeglasses Y N

Hearing aid Y N Dentures Y N

Previous surgery, year, and type of procedure: :

Indicate the type(s) of anesthesia received in the past, and list any complications or reactions you experienced

Local anesthesia _____

General anesthesia _____

Spinal/epidural _____

Primary care physician:

Name : _____ Date of last visit: _____

Address: _____ Telephone () _____

Women patients only:

Number of pregnancies _____ Number of children: _____

Did you breast feed? Y N Last menstrual period: _____