katharine c. nitta
Plastic and Reconstructive Surgery
M.D. F.A.C.S

MEDICAL HISTORY FORM

REASON FOR VISIT: _____

REFERRING PHYSICIAN: _____

HISTORY OF PRIOR SURGERIES OR HOSPITALIZATIONS: _____

HISTORY OF TAKING PAIN MEDICATIONS and HOW EFFECTIVE WAS IT? _____

_____

HISTORY OF ANESTHESIA PROBLEMS: □ Yes □ No

BLOOD RELATIVES WITH HISTORY OF ANESTHESIA PROBLEMS: □ Yes □ No

BLOOD RELATIVE WITH PERTINENT MEDICAL HISTORY: (Cancer, high blood pressure, stroke, heart attack, etc.)

_____

_____

STATED WEIGHT AND HEIGHT: HEIGHT _____ WEIGHT _____

List of Medications: (Diet Pills, Herbals, Vitamins, Over the Counter, Prescription Drugs)

□ Med: _____ Dose: _____ Frequency: _____
□ Med: _____ Dose: _____ Frequency: _____
□ Med: _____ Dose: _____ Frequency: _____
□ Med: _____ Dose: _____ Frequency: _____

Medication Allergies: □ Yes □ No

□ Med: _____ Reaction: _____
□ Med: _____ Reaction: _____
□ Med: _____ Reaction: _____
□ Med: _____ Reaction: _____

Latex Allergy: □Yes □No If yes, indication reaction: _____
Adhesive Tape Allergy: □Yes □No If yes, indication reaction: _____
Iodine/ Shellfish Allergy: □Yes □No If yes, indication reaction: _____
Food Allergies: □Yes □No If yes, indication reaction: _____

HEALTH HISTORY: Do YOU experience any of these symptoms?

Seizure disorders?	□Yes □No	If yes, please explain_____
Blackouts/Fainting	□Yes □No	If yes, please explain_____
Headaches/Migraines?	□Yes □No	If yes, please explain_____
Neck stiffness/pain?	□Yes □No	If yes, please explain_____
Neck injury?	□Yes □No	If yes, please explain_____
Prior stroke?	□Yes □No	If yes, please explain_____
Psychiatric Disorders?	□Yes □No	If yes, please explain_____
Recreational drug?	□Yes □No	If yes, please explain_____
Alcohol use?	□Yes □No	If yes, how much? _____
Do you smoke?	□Yes □No	If yes, how much? _____

Hearing loss?	□Yes □No	If yes, please explain_____
Vision lenses?	□Yes □No	If yes, please explain_____
Corrective lenses?	□Yes □No	If yes, please explain_____
Dry Eyes?	□Yes □No	If yes, please explain_____
Eye Pain?	□Yes □No	If yes, please explain_____
Nose Bleeds?	□Yes □No	If yes, please explain_____
Runny Nose?	□Yes □No	If yes, please explain_____
Nasal Congestion?	□Yes □No	If yes, please explain_____
Seasonal Allergies?	□Yes □No	If yes, please explain_____
Broken Nose?	□Yes □No	If yes, please explain_____

Denture Problems?	□Yes □No	If yes, please explain_____
History of cold sores?	□Yes □No	If yes, please explain_____
Dental Problems?	□Yes □No	If yes, please explain_____
Bleeding Disorder?	□Yes □No	If yes, please explain_____
Heart attack?	□Yes □No	If yes, please explain_____
Chest pain?	□Yes □No	If yes, please explain_____
Heart palpitations?	□Yes □No	If yes, please explain_____
Heart murmurs?	□Yes □No	If yes, please explain_____
Mitral valve Prolapse?	□Yes □No	If yes, please explain_____
High blood pressure?	□Yes □No	If yes, please explain_____

Shortness of breath?	□Yes □No	If yes, please explain_____
Asthma/Wheezing?	□Yes □No	If yes, please explain_____
Pneumonia?	□Yes □No	If yes, when? _____
Chronic cough?	□Yes □No	If yes, please explain_____
History of Tuberculosis?	□Yes □No	If yes, please explain_____
Lung Disease?	□Yes □No	If yes, please explain_____

Breast pain?	□Yes □No	If yes, please explain_____
History of breast cancer?	□Yes □No	If yes, please explain _____
Fibrous breast tissue?	□Yes □No	If yes, please explain_____

Last mammogram? Month: _____ Year: _____ Facility: _____

Breast feeding history? □Yes □No Number of children breast fed: _____ Problems? □Yes □No

Diabetes?	□Yes □No	If yes, please explain_____
Gastric Reflux?	□Yes □No	If yes, please explain_____
Ulcerative Colitis?	□Yes □No	If yes, please explain_____
Peptic ulcer?	□Yes □No	If yes, please explain_____
Kidney Disease?	□Yes □No	If yes, please explain_____
Liver disease?	□Yes □No	If yes, please explain_____
Abdominal pain?	□Yes □No	If yes, please explain_____

History of Hepatitis?	□Yes □No	If yes, please explain_____
Venereal Disease?	□Yes □No	If yes, please explain _____
HIV?	□Yes □No	If yes, please explain_____

_____ _____

Patient Signature Date