

Mammogram History -

- Never had one Its results were -
 LAST mammogram was done in (year) _____
 Normal
 Don't know or remember
 Abnormal Specify _____

Medications - Do you take **ANY Medications** (including Aspirin, Advil etc), **Herbs** or **Supplements**? Yes No

- Medication** - _____ Dose/Frequency - _____ **Medication** - _____ Dose/Frequency - _____
Medication - _____ Dose/Frequency - _____ **Medication** - _____ Dose/Frequency - _____
Medication - _____ Dose/Frequency - _____ **Medication** - _____ Dose/Frequency - _____
Medication - _____ Dose/Frequency - _____ **Medication** - _____ Dose/Frequency - _____
Other(s) - _____

Do you presently have OR have you experienced the following ?

(Check only if you presently **Have or Had** in the past any of the following)

<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Dry or Itchy Eye(s)	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> AIDS or HIV+ status	<input type="checkbox"/> Electrolysis Treatment	<input type="checkbox"/> Nipple Discharge / Retraction
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Fever Blisters	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Persistent Cough
<input type="checkbox"/> Artificial Joint Replacement	<input type="checkbox"/> Head Aches	<input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease or Murmur	<input type="checkbox"/> Reproductive Disorder
<input type="checkbox"/> Birth Defect(s)	<input type="checkbox"/> Heart Valve Surgery	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Breast Lumps or Masses	<input type="checkbox"/> Hepatitis or Jaundice	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Breast Cancer History - Personal	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Problem(s)
<input type="checkbox"/> Breast Cancer History - Family	<input type="checkbox"/> Persistent Hoarseness	<input type="checkbox"/> Stroke
<input type="checkbox"/> Carpal Tunnel Syndrome	<input type="checkbox"/> Hospitalized for ANY reason	<input type="checkbox"/> Thyroid Problem(s)
<input type="checkbox"/> Cancer - Specify _____	<input type="checkbox"/> Kidney Problem(s)	<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Colitis	<input type="checkbox"/> Large Weight Loss	<input type="checkbox"/> Ulcer(s)
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Liver Problem(s)	<input type="checkbox"/> Venereal Disease(s)
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Lupus	<input type="checkbox"/> Vision Problem
<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Mental Illness or Depression	<input type="checkbox"/> Weight loss Treatment

List all your Previous Surgical Operations -

- Operation** - _____ Year - ____ **Operation** - _____ Year - ____
Operation - _____ Year - ____ **Operation** - _____ Year - ____
Operation - _____ Year - ____ **Operation** - _____ Year - ____

Have you been EVER been OR, WHEN you were Last checked for			
		Year	The results were
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Don't know or remember
HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Don't know or remember

When is the **LAST** time you used one of the following (EXCLUDING Tylenol): Aspirin, Advil, Alleve, Motrin, Alka seltzer, Nuprin, Goody's powder, BC powder, prescription or OTHER over-the-counter Arthritis medications ? _____



I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence. It is my responsibility to inform Drs. Aldea and, or Eby of Cosmetic Surgery Specialists of Memphis, PLLC of *any* changes in my address, phone numbers and medical status.

Name (Please, print) - _____ Signature-Adult patient - _____



Cosmetic Surgery Specialists of Memphis, PLLC

Peter A. Aldea, M.D., F.A.C.S.

Patricia L. Eby, M.D., F.A.C.S.

HEALTH HISTORY

To best serve your medical needs, we need you to fully and accurately complete this *entire* form.

The information you disclose is completely confidential and privileged.

Today's Date - _____

Your Name (Please, print) - _____ Age - _____ years

Purpose of your visit _____

- Have you seen *another* Plastic surgeon for this problem ? Yes No Name of surgeon(s) _____

- Why did you choose to see Dr. Aldea or Dr. Eby in consultation - _____

Area(s) of most concern to you (in order of <i>decreasing</i> importance; 1=most important, 2=less important, etc.)	Describe the problem(s) with this area as you see it	What would <u>you</u> like to be done
1.	_____ _____ _____	_____ _____ _____
2.	_____ _____ _____	_____ _____ _____
3.	_____ _____ _____	_____ _____ _____
4.	_____ _____ _____	_____ _____ _____

Allergies

Do you have ANY drug allergies ? No Yes if Yes, please name the drug and its associated reaction(s)-

Drug - _____ - Reaction _____ Drug - _____ - Reaction _____

Drug - _____ - Reaction _____ Drug - _____ - Reaction _____

Are you allergic to - Beef products Cosmetics Fabrics Aspirin Shellfish/Iodine Latex Tape

Life style

- Do you smoke ? No Yes ?-____ Packs/day ? -____ years Do you consume alcohol ? Yes No

- Do you use tobacco or Nicotine in *other* forms (Nicotine Patch or gum, chew, snuff, etc.) ? Yes No

- Do you have a history of either drug and / or alcohol abuse ? Yes No specify - _____

Medical History

- Your current physical health is Good Fair Poor Are you under the care of a physician ? Yes No

Print his/her Name- Dr. _____ Date of your last COMPLETE physical examination -____/____/____

- Do you have ANY medical problems ? Yes No if yes, please name - _____

- Please, list any *other* medical condition(s) you experience(d) - _____

- Are you being treated for ANY medical condition(s) at this time ? No Yes specify - _____

- Have you been treated for psychological problems like depression ? No Yes specify - _____

- Do you have Lupus, Scleroderma, Rheumatoid Arthritis, or other Auto-immune disorders? Yes No

Breast History (for women ONLY)

- Have YOU had or have *any* Breast disease or surgery? No Yes specify- _____

- Do you have a FAMILY history of Breast disease ? No Yes specify- _____