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)

☐	Abnormal Bleeding	☐	Dry or Itchy Eye(s)	☐	Mitral Valve Prolapse
☐	AIDS or HIV+ status	☐	Electrolysis Treatment	☐	Nipple Discharge / Retraction
☐	Alcohol Abuse	☐	Fever Blisters	☐	Pacemaker
☐	Arthritis	☐	Glaucoma	☐	Persistent Cough
☐	Artificial Joint Replacement	☐	Head Aches	☐	Psychiatric Treatment
☐	Asthma	☐	Heart Disease or Murmur	☐	Reproductive Disorder
☐	Birth Defect(s)	☐	Heart Valve Surgery	☐	Rheumatic Fever
☐	Breast Lumps or Masses	☐	Hepatitis or Jaundice	☐	Sickle Cell Anemia
☐	Breast Cancer History - Personal	☐	High Blood Pressure	☐	Sinus Problem(s)
☐	Breast Cancer History - Family	☐	Persistent Hoarseness	☐	Stroke
☐	Carpal Tunnel Syndrome	☐	Hospitalized for ANY reason	☐	Thyroid Problem(s)
☐	Cancer - Specify _____	☐	Kidney Problem(s)	☐	Tuberculosis (TB)
☐	Colitis	☐	Large Weight Loss	☐	Ulcer(s)
☐	Diabetes Mellitus	☐	Liver Problem(s)	☐	Venereal Disease(s)
☐	Difficulty Breathing	☐	Lupus	☐	Vision Problem
☐	Drug Abuse	☐	Mental Illness or Depression	☐	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	☐Yes ☐No	_____	☐Negative ☐Positive ☐Don't know or remember
HIV	☐Yes ☐No	_____	☐Negative ☐Positive ☐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 ***decreasing*** importance; 1=most important, 2=less important, etc.)		Describe the problem(s) with this area as you see it	What would you 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 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-_____