PLASTIC SURGERY ASSOCIATES OF MONTGOMERY, P.C.

Dr. Michael P. Bentley
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HISTORY SHEET

Date of Appointment: ________________

Name: ____ Age: __________ Birth Date: _________________

Height: ________ Weight: _______ Referred By: _________________________ Social Security #______________________

Martial Status (circle one): Married - Single - Divorced - Widowed Race:___________________________________

CHIEF COMPLAINT (WHY YOU WISH TO BE SEEN):

____

____

PLEASE LIST ALL MAJOR SYMPTOMS BELOW:

____

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____

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____

PAST MEDICAL HISTORY:_____Have you been diagnosed or are you being treated for any medical conditions? Please list:

____

____

NAME OF YOUR REGULAR/FAMILY PHYSICIAN:____

LIST THE NAMES OF ANY PHYSICIANS YOU HAVE SEEN IN THE LAST SIX (6) MONTHS:________________________________

____

LIST ALL SURGERIES THAT YOU HAVE HAD AND APPROXIMATE YEAR:

____

____

____

DRUG REACTIONS/ALLERGIES/LATEX SENSITIVITY:

Please list below regarding any known drug allergies or reactions, or sensitivities:

Medication Name | Type of Drug Reaction / Allergy

____

____

____

☐ I do **not** have any known drug allergies or drug reactions.
Are you latex sensitive: ☐ **Yes** ☐ **No**

PRESCRIPTION MEDICATIONS:

Please list all prescription medication you currently take:

____

____

____

____

☐ I am **not** currently taking any prescription medications.
☐ Name of Pharmacy that you use____________________ Phone #__________

NON-PRESCRIPTION MEDICATION / DIETARY SUPPLEMENTS / VITAMINS/ "HERBS"/ MINERALS:

Many patients take non-prescription medications such as aspirin, anti-inflammatories (Advil, Motrin, Alleve) and other preparations that can be purchased without a prescription (dietary supplements, vitamins, "herbs", and minerals. If you currently take items in this category, or have taken any within the last six months, please list:

____

____

____

☐ I am **not** currently taking any non-prescription medications, dietary supplements, vitamins, herbs, or minerals.

TOBACCO USE:

Patients who are currently smoking /using tobacco are at greater risk for surgical complications and delayed healing. These complications are attributable to tobacco use. Please indicate your current status regarding tobacco use:

☐ Never ☐ Cigarettes ________packs/day ☐ Snuff ☐ Cigars ☐ Pipe ☐ Chewing tobacco

☐ I have quit smoking/use of tobacco as of ______________________

How long did you smoke/use tobacco?______________________

REVIEW OF SYSTEMS: Please check Yes (do not answer if unsure). In the past few months, have you had?

HEAD AND NECK:

Any eye disease, faulty sight or eye pain	Yes _______
Any ear disease or impaired hearing	Yes _______
Any trouble with nose, sinuses, mouth or throat	Yes _______
Trouble swallowing	Yes _______
Hard lumps on tongue, lips or mouth	Yes _______
Glaucoma	Yes _______

CARDIOVASCULAR:

Chronic/frequent cough, chest pain, angina	Yes _______
Spitting up of blood	Yes_______
Nightsweats, chills or fever	Yes_______
Shortness of breath	Yes _______
Wake up short of breath	Yes _______
Palpation or fluttering of heart	Yes _______
Swelling of hands, feet or ankles	Yes _______
Rheumatic fever	Yes _______
Tuberculosis	Yes _______
High or low blood pressure	Yes _______
Heart murmur	Yes _______
Heart attack	Yes _______
Emphysema	Yes _______
Vein Thrombosis - DVT (blood clots)	Yes _______

GASTROINTESTINAL:

Stomach trouble, ulcer or pain	Yes _______
Indigestion, vomiting or nausea	Yes _______
Liver or gallbladder disease	Yes _______
Hemorrhoids or rectal bleeding	Yes _______
Any black bowel movement	Yes _______
Constipation or diarrhea	Yes _______
Recent change in bowel action or stools	Yes _______
Cirrhosis of liver	Yes _______
Jaundice (yellow jaundice)	Yes _______

GENITAL-URINARY:

Kidney disease or stone	Yes _______
Bladder disease	Yes _______
Albumin, sugar, pus or blood in urine	Yes _______
Difficulty controlling urine	Yes _______
Difficulty or pain on urination	Yes _______
Urinate more often than usual	Yes _______

ENDOCRINE:

Abnormal thirst	Yes _______
Diabetes	Yes _______
Thyroid disease	Yes _______
Any diabetes in family	Yes _______
Have you ever taken insulin tablets for diabetes, hormone shots or tablets?	Yes _______

If yes, specify:_______________________________________

BONES AND JOINTS:

Arthritis or rheumatism	Yes _______
Broken bones	Yes _______

HEMATOLOGY:

Anemia (low blood)	Yes _______
Do you bleed or bruise easily	Yes _______
Any unusual bleeding after surgery	Yes _______
Any family member a free bleeder	Yes _______

NEUROLOGICAL:

Fainting spells	Yes _______
Loss of consciousness	Yes _______
Convulsions/epilepsy (fit)	Yes _______
Paralysis attacks	Yes _______
Dizziness	Yes _______
Often or severe headaches	Yes _______
Migraine headaches	Yes _______
Nervous breakdown	Yes _______

INTEGUMENT:

Moles that have changed	Yes _______
History of fever blisters	Yes _______

ALLERGIES:

Hay fever	Yes _______
Hives or eczema	Yes _______
Food allergies	Yes _______

PREGNANCIES:

Total Number	__________
How many children born alive	__________
Are you or might you be pregnant now	Yes _______
Any female trouble now	Yes _______

FAMILY HISTORY: List any immediate family members who have had significant medical problems or early deaths: (e.g. heart disease. Cancer, lung disease, bleeding disorders)

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****** NOTE ******

THIS IS A CONFIDENTIAL REPORT OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HEREIN WILL NOT BE RELEASED TO ANY PERSONS EXCEPT WHEN YOU HAVE AUTHORIZED US TO DO SO.