BLUE RIDGE PLASTIC SURGERY GROUP
HEALTH INFORMATION

TODAY'S DATE ___________________

FULL NAME ____ DATE OF BIRTH__________________

REFERRING PHYSICIAN ______________________________ PHONE ______________________

PRIMARY CARE PHYSICIAN ___________________________PHONE ______________________

REASON FOR VISIT:____
____
____

Previous treatments for this problem:____
____

List your other current health problems:____
____

Current Medications: ____
Vitamins/Supplements: ____
Anything else taken regularly: ____
Medication Allergies: Yes ☐ No ☐ If yes, allergy to what: _______________________

PREVIOUS MEDICAL HISTORY

Have you ever been treated for or diagnosed with:

- Wound healing problems Y N
- Bleeding or clotting problems/tendencies Y N
- Lung disease (Asthma, TB) Y N
- Liver disease or hepatitis Y N
- Excessive scarring or keloid formation Y N
- Diabetes Y N
- Heart disease (angina or other) Y N
- Blood pressure problems Y N

Any other medical problems ____
____
____

PREVIOUS SURGICAL HISTORY

Operations	Anesthesia type	Date	Problems

SOCIAL HISTORY

Occupation ____ for how long ________________
Tobacco use? Y N if so, how much? ____
Alcohol use? Y N if so, what and how much? ___________________
Have you followed a skin care regimen? If so please list__________________________
____
Is there any chance you are pregnant? ____________________ Are you trying to get pregnant? Y N
Recent weight loss? __________How much? ____________ Are you trying to lose weight? _______________
____
Hobbies, activities you consider important to you:______________________________________
____
How often do you see your primary care physician? ________________________Date of last visit:___________________
Additional comments ____
____

I confirm, to the best of my knowledge, that the answers that I have given are correct and that I have not withheld any information that may be relevant to my treatment.

____
Signature