

# MEDICAL HISTORY

CAROLINA COASTAL PLASTIC SURGERY & MEDICAL SPA  
1275 21<sup>ST</sup> AVE NORTH  
MYRTLE BEACH, SC 29577

PATIENT NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Please answer all of the questions as accurately as possible. If you do not understand the question, please ask for assistance.

PRIMARY CARE DOCTOR: \_\_\_\_\_

Smoking (type & amount per day) \_\_\_\_\_

Alcohol (type & amount per week) \_\_\_\_\_

DRUG ALLERGIES: _____	PREVIOUS SURGERIES, MAJOR ILLNESSES AND HOSPITALIZATIONS: _____
Medications Taken, including _____	_____
Non-prescription drugs, vitamins & herbs _____	_____
Date: _____	

**\*\*IF YOU NEED MORE SPACE FOR ANSWERS, TURN PAGE OVER\*\***

## FAMILY HISTORY

Has any blood relative ever had the following:

Breast Cancer	No	Yes	High Blood Pressure	No	Yes	Kidney Disease	No	Yes
Melanoma	No	Yes	Heart Disease	No	Yes	Depression	No	Yes
Stroke	No	Yes	Diabetes	No	Yes			

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## PAST MEDICAL HISTORY

Have you ever had the following:

Heart Disease	No	Yes	Cancer	No	Yes	Stomach Ulcer	No	Yes
Arthritis	No	Yes	Glaucoma	No	Yes	Kidney Disease	No	Yes
Rheumatic Fever	No	Yes	Asthma	No	Yes	Thyroid Disease	No	Yes
Anemia	No	Yes	AIDS or HIV+	No	Yes	Bleeding Tendency	No	Yes
Tuberculosis	No	Yes	Stroke	No	Yes	Mitral Valve Prolapse	No	Yes
Diabetes	No	Yes	Hepatitis	No	Yes	High Blood Pressure	No	Yes
Nervous Illness	No	Yes	Chemical Dependency	No	Yes			

## REVIEW OF SYSTEMS

Do you have now or have you had within the past year:

Weight Change	No	Yes	Swollen feet/Ankles	No	Yes	Seizures	No	Yes
Dry Eyes	No	Yes	Skin Rash	No	Yes	Joint or Muscle pain	No	Yes
Chronic Cough	No	Yes	Chronic Diarrhea	No	Yes	Swollen Lymph Nodes	No	Yes
Chest Pain	No	Yes	Jaundice	No	Yes	Easy Bleeding	No	Yes
Rapid Heart Beat	No	Yes	Depression	No	Yes	Easy Bruising	No	Yes

## WOMEN ONLY

Age period began \_\_\_\_\_ Date of Last Period \_\_\_\_\_ Number of Pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_

Date of last Mammogram \_\_\_\_\_ Did you breast feed? Yes No

Do you regular breast self-examination? Yes No Breast lump or Discharge? Yes No

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature of patient or guardian of minor \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Updated \_\_\_\_\_ Date \_\_\_\_\_

Updated \_\_\_\_\_ Date \_\_\_\_\_