History and Physical

Plastic Surgery Institute of Dayton, Inc. & PSI Surgery Center, LLC
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Patient's Name: ________________________, Date ________, Birthday _________, Age _____, Height _____, Weight _______
History of Present Illness: Where and what is the problem/diagnosis?________________________________
How long has problem been present?_________ Has it changed and how (bigger/smaller)? ____________________
How painful or severe 1-5____? Color/change?______ Bleeding?___ Scaly?___ Crusty?___ Past treatments?________________
What makes it better or worse?____

☐ Accident? ☐ Work related Injury? Date of injury? _________ Referring Doctor? ______________________

Would you like information on cosmetic surgery or procedures? ☐ Yes ☐ No
If yes, which procedures are you interested in? ________________________________
Current Medication: Please include non-prescription drugs; Aspirin, Advil, Motrin, Ibuprofen, Excedrin, Aleve, Naprosyn, Midol, Pamprin, Vitamins, Herbal remedies. Please list drug name, dosage and schedule. (Example: Tylenol 325mg 2 pills three times a day)

1) ______________________ 5) ______________________ 9) ______________________
2) ______________________ 6) ______________________ 10) ______________________
3) ______________________ 7) ______________________ 11) ______________________
4)______________________ 8) ______________________ 12) ______________________

Drug Allergies: Circle **all** that apply: None, Penicillin, Sulfa, Codeine, Erythromycin, LATEX, Suture, Adhesive/Tape
Other:____
Reactions: hives, rash, nausea, vomiting, sick, breathing problems, swelling, **Other:**____________________
Advanced Directives: ☐ None ☐ Living Will ☐ Health Care Power of Attorney ☐ Do Not Resuscitate

Past Medical History: **(**check all that apply) ☐ NONE

☐ AIDS/HIV	☐ Bleeding Problem	☐ Gastric Bypass	☐ Hepatitis	☐ Psychiatric Care	☐ TB
☐ Alcoholism	☐ Cancer	☐ Glaucoma	☐ High Blood Pressure	☐ Radiation Therapy	☐ Thyroid Problem
☐ Anemia	☐ Chest Pain/ Tightness	☐ Healing Problems	☐ High Cholesterol	☐ Skin Cancer	☐ Transfused
☐ Anesthesia Problem	☐ COPD	☐ Heart Attack	☐ Kidney Disease	☐ Sleep Apnea	☐ Ulcers
☐ Arthritis	☐ Dentures	☐ Heart Disease	☐ Liver Disease	☐ Stents/Heart Surgery	
☐ Asthma	☐ Depression/Anxiety	☐ Heart Murmur	☐ Melanoma	☐ Stroke	
☐ Autoimmune Disorder	☐ Diabetes	☐ Heartburn/ Reflux	☐ Pacemaker/Defibrillator	☐ Substance Abuse	

☐ **OTHER**____

Females only: ☐ Menopause ☐ Fibrocystic Disease ☐ BRCA Gene ☐ Breast Cancer ☐ Ovarian Cancer ☐ Tubal Ligation
☐ Hysterectomy ☐ C-section Last Mammogram Date: _______________☐ Currently Pregnant ☐ Plan on becoming pregnant?
☐ #of Pregnancies ____ ☐ # of Live Births ____ Ages of Children? ___________ Bra Size __________
Past Surgical History: 1) ____________________ 2) ____________________3) ____________________
4) ____________________ 5) ____________________6) ____________________ 7)____________________
Family History: Has any family member had any of these conditions? (Circle) Heart, Lung, Liver, Kidney, Brain Disease, Cancer & Type, Diabetes, High cholesterol, Hypertension,
Other:____

Social History: **Profession**:______________________________, Status:☐ Married, ☐ Single, ☐ Widowed, ☐ Divorced
# of Alcoholic drinks____per day/week/month. **Smoking #** of cigarette packs per day _____ # of years smoking _____ ☐ Caffeine
☐ **History of drug/alcohol abuse**? ☐ Recreational Drugs?_________________ **Exercise**? Cardio/weights ☐ dieting ☐ weight loss
Ethnicity: (Circle); African American, Hispanic, Asian, Caucasian, Native American, other: ______________________

System Review: (Circle all that apply)

General	None; Fever, Chills, Weight Loss, Weakness
HEENT	None; Vision changes, Blind, Double vision, Dry Eyes, Sinus Problem, Nasal Congestion, Ringing, Headache, Head Injury, Snoring, Dental disease, Sore Throat, Broken Nose/Face, Blocked Nose, Nose bleeds, Swollen glands, Dentures, Neck Pain, Hearing Loss, Hard to Swallow, Jaw Pain, Tearing, Seasonal Allergies
Cardiology	None; Chest pain, Heart Failure/Fluid in Lungs; Palpitations (racing heart), Short of breath w/activity, Fainting, Irregular Heart Rate, Waking Up Short of Breath, Rheumatic Fever, A-fib
Pulmonary	None; Asthma/Wheezing, Bronchitis, Cough, Coughing up Blood, Shortness of Breath, Pneumonia
GI	None; Heartburn, Poor Appetite, Nausea/Vomiting, Diarrhea, Constipation, Bloody Stool, Jaundice, Belly Pain, Hernia
GU/Renal	None; Dialysis, Kidney Stones, Kidney/Bladder Infections, Bloody Urine, Incontinence, Pain or Freq. Urination
Vascular	None; Heart/Vascular Disease of Artery/Veins, Vasculitis, Leg Swelling, DVT, Clot, Embolism, Calf Pain
Neurological	None; Headache, Epilepsy/Seizures, Date of last seizure__________ , Spinal Cord Injury, Paralysis, Brain/ Nerve Tumor, Head injury, Dizzy, Nerve Pain, Sciatica, Numbness, Weakness
Hematological	None; Leukemia, Sickle cell, Anemia, Bleeding, Blood clots, Bruising, Radiation, Chemotherapy
Endocrine	None; Swollen Lymph Nodes, Diabetes Type I, II # yrs___; Chronic Steroid Use ___yrs.; Always Hot/Cold, Hypo or Hyper Thyroid, Excessive thirst, Fluid Retention, Hot flashes, Menopause, Hairy, Hair Loss
Skin	None; Acne, Cellulitis, Pressure Ulcers, Difficulty Healing, Basal Cell, Squamous Cell, Keloid, Melanoma, Eczema, Warts, Growths, MRSA, Pressure relief, Orthotics, Scaly, Rash, Itching, Bleeding Lesions, Skin Cancer, Ulcer, Frequent Sunburn, Dry Skin
Musculoskeletal	None; Weakness, Fractures, Arthritis, Immobility, Osteomyelitis, Gout, Muscle/Joint/Back Pain
Infectious Disease	None; MRSA, TB, Hepatitis A, B,C, AIDS / HIV, Herpes, Immunizations, Tetanus Shot, Zoster Shot
Psych	None; Disorientation, Unusual thoughts, Depression, Anxiety, Addiction, Insomnia

Please, it is *important* that you fill in all of the blanks:

Referred by Physician/Specialist____Phone_____________________________
Address____ City________________________________ Zip ___________
Family Physician____Phone________________________________
Address____City_________________________________Zip ___________

STATEMENT OF RELEASE: May we leave a message concerning **your health information and appointments** with a family member or other designated person(s) or on your answering machine? ☐ Yes ☐No

FAMILY MEMBER OR DESIGNATED PERSON(S):

Name____Relationship_________________Phone_________________________
Name____Relationship _________________Phone ________________________
Patient Signature____Date__________________________

Authorization for Disclosure of Information: I authorize Drs. Schmidt, Fox and Hedrick to disclose complete information concerning his/their medical findings and treatment of the undersigned, from the initial office visit until the date of conclusion of such treatment, to those individuals who, in my physician's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Patient Signature____ Date______________________
Witness____Date______________________

DOCTORS ONLY:

PHYSICAL EXAM: Vitals: Temp.______ Pulse______ Resps.______ BP________

General: well developed, well nourished, obese anorexic, emaciated, oriented, confused, depressed, anxious

HEENT: ☐ NCAT, AOx3, CN II-XII, PERRLA, EOMI, MMM, Nl Hearing, Nl Vision, Ø mass, Ø bruits, Ø Nodes______________

Heart: ☐ RRR, nl s1/s2 Ø GRM Ø JVD ____

Chest: ☐ CTAB, no WRRC, BS = , AE good, Ø breast mass, Ø nodes ____

Abdomen: ☐ Soft, NT ND BS+, ØHSM, Ø mass, ☐ Hernia____

Skin: Location______________________ Size______ Reg/Irreg Border, Color: Br/Bk/Bl/Red/Tan, Mac/Pap, Scaly, Irritated, Itches
Location______________________ Size______ Reg/Irreg Border, Color: Br/Bk/Bl/Red/Tan, Mac/Pap, Scaly, Irritated, Itches
Location______________________ Size______ Reg/Irreg Border, Color: Br/Bk/Bl/Red/Tan, Mac/Pap, Scaly, Irritated, Itches

Other/X-RAY/path/lab:_____________________-____ ☐ ***see pictogram***

IMPRESSION/PLAN: ____
____
____

Patient Needs: ☐CBC ☐BMP ☐PT/APTT ☐EKG ☐Mammogram **Clearance**: ☐Medical ☐Cardiac ☐ No need for medical testing ☐ Other testing____________________________ **Facility For Surgery**: ☐ Hospital ☐ PSI ☐ Patient is able to tolerate surgery

Anesthesia: ☐ General ☐ Local ☐ IV Sed **CONCUR W/ ANESTHESIA PLAN** ☐Yes ☐No **OP TIME REQUIRED:**___________

Equipment:____

Pre-op RX: ☐ Neurontin ☐ Celebrex ☐ Lovenox ☐ Valtrex ☐ Scopalomine Patch ☐ Tylenol

☐ Other____

DOCTOR'S SIGNATURE:____DATE:______________