History and Physical for Dayton Plastic Surgery Institute of Dayton & PSI Surgery Center Drs. S. Schmidt, M. Fox and J. Hedrick MD 9985 Dayton Lebanon Pike, Centerville, Ohio 45458 Phone: 937-886-2980 FAX: 937-886-2982

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, Aspirin, Erythromycin, LATEX, other**?**______________

Please list reactions; hives, rash, nausea, vomiting, sick, breathing problems, swelling, other? ______________________________

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	□ Other ____________
□ Autoimmune Disorder	□ Diabetes	□ Heartburn/acid reflux	□ Pacemaker/Defibrillator	□ Substance Abuse	____________

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 the blanks:

Referred by ______________________________ Phone__________________
Address__________________________________ City_________________ Zip _______
Family Physician__________________________ Phone__________________
Address__________________________________ City_________________ Zip_______
Other physician (example: specialist)________________________ Phone_________________
Address__________________________________ City_________________ Zip_______

STATEMENT OF RELEASE: May we leave a message concerning **<u>your health information and appointments</u>** 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: **General:** well developed, well nourished, obese anorexic, emaciated, oriented, confused, depressed, anxious

<u>PHYSICAL EXAM</u>: Vitals: Temp._____ Pulse_____ Resps._____ BP_______
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***
<u>IMPRESSION/PLAN:</u> ____

Time spent counseling patient_____.□The dx, procedure, risks, complications, tx options, expected post-op course, and questions were fully d/w pt.
Time needed for excision: __________________ Anticipated repair length__________ Simple, Intermediate, Complex
Implant Style/Size: ____________________________ □ ***see pictogram***
Functional: Y N, Insurance: Y N, Prior Auth. Needed: Y N, Pre-Cert Needed: Y N, High Deductible: Y N___________
Tiers: Y ____________ N , Office in Network: Y N, PSI in Network Y N, Cosmetic: $_______Paid:______ Due:_____

<u>Patient Needs</u>: □CBC □BMP □PT/PTT □EKG □CXR □Mammogram, **<u>Facility</u>**: □ MVH, □ KMC, □ SYC □ CMC, □ PSI, □ other:______________ **CLEARANCE**: □medical □cardiac □ <u>No</u> need for medical testing □ Patient <u>is</u> able to tolerate surgery
<u>Anesthesia</u>: □ general □ local □ IV Sed **CONCUR W/ ANESTHESIA PLAN**□Yes □No **OPERATIVE TIME REQUIRED:**_____
Equipment:____
Preop RX:□ZPack □Cipro □Vicodin □Valtrex □Emend □Ativan □Bactrim □Percocet □Clonadine □Augmentin □Doxycycline □other____

DOCTOR'S SIGNATURE:____DATE:______________