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, 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 the blanks:

Referred by Physician/spicialist_____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:_____
Preop RX: □Neurontin □Celebrex □Lovenox □Valtrex □Scopalomine Patch □Tylenol
□other_____

DOCTOR'S SIGNATURE:_____DATE:_____