LOUIS A. BONALDI M.D. F.A.C.S.
center for plastic surgery

Patient History

Patient Name: **First** _____**M.I.** ____**Last** _____

Date of last physical _____/_____/_____ Height ____'____" Weight _____ lbs

Please list all food/drug allergies: _____

Are you allergic or sensitive to latex? **Y** or **N**

List all Medications (include over the counter and homeopathic drugs/vitamins):

	Medicine	Dose	How Often
1.			
2.			
3.			
4.			
5.			

What is your daily consumption of: Tobacco _____ *packs per day* Alcohol _____

Do you suspect that you may be pregnant? **Y** or **N** Date of last mammogram _____/_____/_____

List all operations you have had:

	Surgery	Year	Surgeon
1.			
2.			
3.			
4.			
5.			

Have you been hospitalized? **Y** or **N**

List any family history of significant illness (blood clots, diabetes, heart disease, melanoma, malignant hyperthermia, cancer, etc.)

_____
_____
_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

YES	NO		Yes	No	
		High blood pressure			Bleeding tendencies
		Stroke			Anemia
		Heart attack			AIDS/HIV
		Irregular heart beat			Transfusions
		Blood clots			Diabetes
		Rheumatic fever			Thyroid problems
		Chest pain			Hepatitis/Jaundice
		Heart murmur			Kidney disease
		Shortness of breath			Stomach ulcers
		Asthma/emphysema/wheezing			Abdominal pain
		Cough			Pancreatitis
		Back or neck injuries			Seizures
		Injuries or fractures			Dizziness/fainting
		Swollen glands			Glasses/contacts
		Frequent ear problems			Visual impairments/dry eye
		Frequent nasal problems			Cataracts
		Skin conditions requiring meds			Mental illness
		Breast lump			Hysterectomy
		Weight gain/loss amount: _____			Other: _____

If you have answered "Yes" to any of the above questions please explain:

_____
_____
_____
_____
_____
_____

Laboratory Tests

Yes	No	
		Blood Tests _____
		EKG (cardiogram) _____
		Chest X-ray/MRI/CT Scan_____
		Other Labs _____