David B. Reath, M.D. PLLC
Celebrating over 25 years as East Tennessee's Plastic Surgeon

The personal approach to personal change.

Name ____________________ Date of Birth ____________________

Primary Care Physician ____________________ Telephone ____________________

Primary Care Physician's Address ____________________ Last Seen ____________________

Other Physicians you have seen in the last year: ____________________

Previous Operations:

1.	date:	5.	date:
2.	date:	6.	date:
3.	date:	7.	date:
4.	date:	8.	date:

Medical Illnesses you are being treated for:

1.	4.	7.
2.	5.	8.
3.	6.	9.

Have you ever had problems with anesthesia? Yes No If so, which type of anesthesia? Local General

What was the nature of the problem? ____________________

Has anyone in your family had a reaction to anesthesia? Yes No

Drug Allergies: ____________________

Food Allergies: ____________________ **Are you allergic to cow's milk?** Yes No

Are you allergic to Latex? Yes No **Are you allergic to x-ray contrast material (Dye)?** Yes No

Prescription Medications:

1.	dose:	6.	dose:
2.	dose:	7.	dose:
3.	dose:	8.	dose:
4.	dose:	9.	dose:
5.	dose:	10.	dose:

What over –the-counter or medications are you taking? ____________________

What vitamins or supplements are you taking? ____________________

Are you taking any diet or weight loss pills? Yes No If so, which ones? ____________________

Do you smoke? Yes No How much? ____________________ How many years? ____________________

If you used to smoke, when did you quit?

Do you drink Alcohol? Yes No How much and what type? ____________________

Have you ever had an Exercise ToleranceTest (Stress Test)? Yes No When? ____________________

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Family History – Has any blood relative had the following?

- ☐ Breast Cancer
- ☐ Melanoma
- ☐ Stroke
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart disease
- ☐ Bleeding Problems
- ☐ Blood clots in the veins of the legs
- ☐ Emphysema

Past Medical History – Have YOU ever had the following?

- ☐ Heart Disease
- ☐ Rheumatic Fever
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Diabetes
- ☐ Stroke
- ☐ Anemia
- ☐ Bleeding disorders
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Hepatitis or liver disease
- ☐ Gastro esophageal reflux disease
- ☐ Psychiatric disease
- ☐ HIV+
- ☐ MRSA infections
- ☐ Kidney disease
- ☐ Blood Clots in the your leg veins

Review of Systems – Have YOU had any of these symptoms (in the last five years)?

- ☐ Weight Change
- ☐ Dry eyes
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Bleeding Problems
- ☐ Easy Bruising
- ☐ Swelling of Feet of Ankles
- ☐ Skin Rash
- ☐ Skin Infections
- ☐ Constipation
- ☐ Heart Burn
- ☐ Problems with Urination
- ☐ Jaundice
- ☐ Depression
- ☐ Passing out or Fainting
- ☐ Seizures
- ☐ Swollen Lymph Nodes (glands)
- ☐ Joint or Muscle Pain
- ☐ Numbness and/or Tingling

Women Only

Age Periods Began ____________

Date of last Mammogram ______________________________________

Number of Pregnancies ____________

Are you breast feeding? Yes No

Have you ever had an abnormal mammogram? Yes No

Do you do breast self-examination? Yes No

Have you ever had a breast biopsy? Yes No

I attest that the health history as noted above is complete and accurate. All prescribed medicines and over the counter supplements and vitamins are listed. I understand that omissions or misrepresentations may affect my personal health, safety and/or the outcome of any of my procedures.

Signature ______________________ Date ______________________