## MEDICAL HISTORY FORM Greater Milwaukee Plastic Surgeons, S.C.

Patient's Name:Fi	rst			MI	Last					
		***						,		
Height:			Weight:			Age:	Age:		y/o	
List your primary phy	sician (or pediatr	ician if c	child):							
List reason for visit or	current medical	problem	(s):							
List medications you	are currently takin	ng:								
Do you have any know	w ALLERGIES	and/or l	DRUG	SENSITIVITI	ES?	No □ Yes, ple	ase list: _			
List any vitamins and	or herbal suppler	nents tha	at you	currently take: _						
List previous operatio	ns with dates:									
Circle "Y" for "Yes",	"N" for "No" in	respons	se to th	e following:						
Do you smoke? Do you drink? Do you bruise easily? Do you take aspirin, il	Y N Y N Y N	How n	nuch poften?	er day?		N				
Family History:	Diabetes Heart Disease	Y Y	N N	Cancer	Y	N				
De vous house mouse on h										
Do you have now or have you ever had breathing problems high blood pressure heart disease epilepsy			N N N N	kidn blad arthi auto	Y Y Y Y	N N N N				
glaucoma or cataracts stomach ulcers hepatitis/jaundice estrogen therapy		Y Y Y	N N N N	bloo puln clo	tis, etc.) Y Y	N N				
psychiatric counseling gout		Y Y	N N	diabetes cancer			Y Y	N N		
Have you ever had a b Would you accept a b				If Yes, enter da emergency situa			sician's ca	re? Y	N	
Are there any medical	problems not list	ted abov	e that y	you would like t	he physic	cian to be inform	ned about?	,		
I certify that the above	e information is c	orrect to	the be	est of my knowle	dge:					
Patient Signature:						Date				