John M. Rowley, M.D.
Palo Verde Plastic Surgery

Patient Medical History

Patient Information

Patient Name: _____

DOB:_____ **Age:**_____ **Gender**_____ **Height:**_____ **Weight:** _____

Race_____ **Ethnicity**_____ **Language**_____ □ **DO NOT WISH TO REPORT**

Do you have an Advanced Directive? _____

MEDICATIONS	DOSAGE	MEDICATIONS	DOSAGE

DATE	SURGICAL PROCEDURE(S)
ANESETHSIA PROBLEMS? (If yes, please list below):	

ALLERGY: Please list all Food and Drug Reaction	

MEDICAL CONDITIONS							
	High blood pressure		Intestinal Problems		Varicose Veins		Wound Healing Issues
	Heart Murmur		Thyroid Problems		TB		Easy Bruising
	Coronary Artery disease		Emphysema		HIV		Seizure
	Heart Failure		Chronic Bronchitis		Liver Disease		Headaches
	Arrythmia		Asthma		Hepatitis		Psychological Disorders
	Stroke		Diabetes**		Blood Clots		Drug Abuse
	Lung Problems		Kidney Problems		Bleeding Tendencies**		
	Cancer		Cholesterol		Sleep Apnea		
	Arthritis		Circulation Problems		Chronic Back Pain		

**** If yes to medical conditions above please explain:**

_____

_____

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List any other medical conditions that were not listed above:

WOMEN'S HEALTH HISTORY	
Contraception Type	
Date & result of Last Mammogram	
**Bra size	

** Breast Surgery Patients are Required to Answer

	FAMILY MEDICAL CONDITION	RELATION: (Mother, Farther, Brother, Sister, PGF, PGM, MGM, MGF)
	Heart Disease	
	Hight Blood Pressure	
	Cancer	
	Circulation Problems	
	Diabetes	
	Stroke	
	Mental Illness	

UNDER PHYSICIAN and /or PAIN MANAGEMENT CARE (please list below)

Tobacco Use		
	Smoke Cigarettes?	Yes / No - (if never smoked, please move to Alcohol/Drug Use)
	Current: Packs/ day_____# of Years _____ **Past**: Quit Date:_____ Packs/day_____# of Years _____	
Alcohol/drug Use		
	Drink alcohol?	Yes / No (if yes, please answer questions below)
	How Often? □ 1 or less a month, □2-4 times per month, □2-3 times a week, □4 or more a week	

PREFERRED PHARMACY (Name, address, and cross streets)

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____

PRINT NAME DATE