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

Palo Verde Plastic Surgery
4545 E Chandler Blvd, Suite 110 ; Phoenix ,AZ 85048
Phone: 480-759-3001 • Fax: 480-759-1341

PATIENT MEDICAL HISTORY

PLEASE FILL OUT COMPLETLEY AND PRINT CLEARLY

FULL LEGAL NAME: _____ **DOB (MM/DD/YYYY):** _____

Height:_____ **Weight:**_____ **Race:**_____ **Ethnicity**_____ **Language**_____

Do You have an Advance Directive? ☐ **Yes** ☐ **No**

****PLEASE PUT DOWN ALL PERSCRIBED, OVER THE COUNTER AND SUPPLEMENTS****

MEDICATIONS	DOSAGE	MEDICATIONS	DOSAGE

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

ALLERGIES

Do You Have ANY of the following Allergies? **Latex :** ☐ Yes ☐ No **Tape :** ☐ Yes ☐ No

Please list all Medication & Food Allergies (Including Reactions)

Med/Food Name	Reaction

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

****Breast Surgery Patients are Required to Answer**

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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	☐	Other (please list below)
☐	Cancer	☐	Cholesterol	☐	Sleep Apnea		
☐	Arthritis	☐	Circulation Problems	☐	Chronic Back Pain		

**** List all other medical conditions here:**

_____

_____

Are you currently under Pain Management Care ? ☐ Yes ☐ No
Provider Name: _____ **Provider Phone:**_____

	FAMILY MEDICAL CONDITION	RELATION: (Mother, Father, Brother, Sister, PGF, PGM, MGM, MGF)
☐	Diabetes	
☐	High Blood Pressure	
☐	Heart Disease	
☐	Stroke	
☐	Mental Illness	
☐	Cancer	

Social History

Do you use Nicotine? ☐ Yes ☐ No - (if never smoked, please move to Alcohol/Drug Use)

Vape? ☐ Yes ☐ No **Cigarettes?** ☐ Yes ☐ No Other Nicotine Products: _____
Current: Packs/ day_____ # of Years _____ **Past**: Quit Date:_____ Packs/day_____# of Years _____

Alcohol/drug Use

Do You Drink Alcohol? ☐ Yes ☐ No
How Often? ☐ 1 or less a month, ☐ 2-4 times per month ☐ 2-3 times a week, ☐ 4 or more a week

PATIENT/RESPONISBLE PARTY PRINTED: _____

PATIENT/RESPONISBLE PARTY SIGNATURE: _____

DATE: _____