WILMINGTON HEALTH

Health History

Name: _____ Birth Date: _____ Age: ____

Reason for Today's Visit: _____
Referring Doctor: _____ Primary Care Doctor: _____

Medications: List dose or number of pills per day.
Prescription Drugs: _____
_____
Non-Prescription Drugs (vitamins, herbs): _____
_____

Regular Aspirin Use: **no** **yes** Dosage and Frequency: _____
NSA (Advil, Motrin, Ibuprofen): **no** **yes** Dosage and Frequency: _____
Drug Allergy: **no** **yes** List drug(s) and type of reaction: _____
_____
_____
List previous operations or major illnesses and dates: _____
_____

Family History

Has any blood relative ever had the following:

Breast cancer	**no** **yes**
High blood pressure	**no** **yes**
Kidney disease	**no** **yes**
Melanoma	**no** **yes**
Heart disease	**no** **yes**
Depression	**no** **yes**
Stroke	**no** **yes**
Diabetes	**no** **yes**

Wilmington Health
Plastic and Reconstructive Surgery
2421 Silver Stream Lane
Wilmington, NC 28401
Phone: 910.762.1234
Fax: 910.762.1232
wilmingtonhealth.com

Name: _____Birth Date: _____ Age: _____

Past Medical History

Have you ever had the following:

Heart disease	no yes	Anemia	no yes
Cancer	no yes	AIDS or HIV+	no yes
Stomach ulcer	no yes	Tuberculosis	no yes
Arthritis	no yes	Stroke	no yes
Glaucoma	no yes	Mitral valve prolapse	no yes
Kidney disease	no yes	High blood pressure	no yes
Rheumatic fever	no yes	Diabetes	no yes
Asthma	no yes	Hepatitis	no yes
Thyroid disease	no yes		

Review of Systems

Do you have now or have you had within the past year:

Weight change	no yes	Swollen lymph nodes	no yes
Swollen feet/ankles	no yes	Chest pain	no yes
Seizures	no yes	Jaundice	no yes
Dry eyes	no yes	Easy bleeding	no yes
Skin rash	no yes	Rapid heart beat	no yes
Joint or muscle pain	no yes	Depression	no yes
Chronic cough	no yes	Easy bruising	no yes
Chronic diarrhea	no yes		

Do you smoke? no yes How much? _____

Do you drink alcohol? no yes How much? _____

Have you ever had local anesthesia? no yes

Occupation: _____

Women only:

Number of children____ Number of pregnancies ____ Did you breast feed? no yes

Age menstrual period began_____

Are you pregnant? no yes

Date of last mammogram _____ Breast lump or discharge? no yes

Do you do regular breast examinations? no yes

I verify that the above information is true and accurate to the best of my knowledge.

_____ Date _____

Signature of patient or parent if minor

Physician's Signature _____ Date _____

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Name: _____Birth Date: _____ Age: _____

Completed by Physician

Physical Exam

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Temp: _____ Respirations: _____

General Status Comment

HEENT: _____

Vision: _____

Pulmonary: _____

CV: _____

Abdomen: _____

Extremity: _____

Skin: _____

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

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