Restifo Plastic Surgery
PLASTIC & RECONSTRUCTIVE SURGERY
Richard J. Restifo, MD Johnny C. Mao, MD P:203.772.1444 F: 203.907.0503

PATIENT HEALTH HISTORY

Name : _____ Age : _____ HT/WT : _____

Please indicate yes or no to the following questions. Your answers are for our records only and will be considered confidential

1. Have you had any serious illnesses or operations? (including cosmetic surgery) Yes No
   If so, please describe _____
2. Have you been hospitalized or had a serious injury within the past 5 years? Yes No
   If so, please describe _____
3. Have you had abnormal bleeding associated with previous surgery or trauma? Yes No
4. Have you ever required a blood transfusion? Yes No
5. Do you have any allergies? Yes No
6. Are you allergic or have you reacted adversely to any of the following:

a. Local anesthesia	Yes	No	e. Aspirin	Yes	No
b. Penicillin or other antibiotics	Yes	No	f. Latex	Yes	No
c. Sulfa drugs	Yes	No	g. Other _____		
d. Barbiturates, sedatives, or sleeping pills	Yes	No	_____		

7. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Including over-the counter medications.** _____

_____

_____

8. Do you smoke? Yes No If so, how much? _____ For how long? _____

Medical History

Have you ever had any of the following? (Please circle the appropriate response)

Heart Disease	Yes / No	Herpes	Yes / No	Tuberculosis	Yes / No
Lung Disease	Yes / No	Venereal Disease	Yes / No	Heart Attack	Yes / No
Diabetes	Yes / No	Syphlis	Yes / No	Joint Replacement	Yes / No
High Blood Pressure	Yes / No	HIV or Aids	Yes / No	Bleeding Tendency	Yes / No
Asthma	Yes / No	Hepatitis	Yes / No	Skin Cancer	Yes / No
Blood Clots in Legs	Yes / No	Stomach Problems	Yes / No	Arthritis	Yes / No
Rheumatic Fever	Yes / No	Mitral Valve Prolapse	Yes / No	Thyroid Disease	Yes / No
		Glaucoma	Yes / No	Kidney Disease	Yes / No
		Rheumatic Heart Disease	Yes / No	Heart Murmur	Yes / No

Family History

Do you or any of your relatives had any of the following? (Please circle the appropriate answer)

Breast Cancer	Yes / No	Diabetes	Yes / No	Cancer	Yes / No
Melanoma	Yes / No	Kidney Disease	Yes / No	If so, what kind? _____	
Heart Disease	Yes / No	Stroke	Yes / No	Any other? _____	
High Blood Pressure	Yes / No	Depression	Yes / No		
Hemophilia	Yes / No	Anemia	Yes / No		

Review of Symptoms

Have you had any of the below listed symptoms in the past year?

Fever & Chills	Yes / No	Weight Change	Yes / No	Swollen Lymph Nodes	Yes / No
Skin Lesions/Rash	Yes / No	Abdominal Pain	Yes / No	Dentures	Yes / No
Headache	Yes / No	Chronic Cough	Yes / No	Wear Contacts	Yes / No
Dry Eyes	Yes / No	Chest Pain	Yes / No	Easy Bruising	Yes / No
Wheezing	Yes / No	Taken Steroids	Yes / No	Anxiety	Yes / No
Urinary infection	Yes / No	Jaundice	Yes / No	Fainting Spells	Yes / No
Swollen Feet	Yes / No	Breast Lump	Yes / No	Stomach Ulcers	Yes / No