

Augusta Plastic Surgery Associates, P.C. • Augusta Plastic Surgery Center, Inc.

PATIENT PERSONAL HISTORY	Date: _____
<small>Confidential Records: Information contained herein will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your physician in his decision(s) regarding your care.</small>	

Name:(Last)		(First)		(Middle)	
Age:	Height:	Weight:	Do You Have A Living Will/DNR? Yes No		
Are You Allergic to Latex? Yes No		Have you ever had a bad staph infection? Yes No If Yes, When?			
List Of Allergies:			Reason For Visit:		

List ALL Current Medications-Prescription & Over The Counter-Include Aspirin, Motrin, Ibuprofen & Vitamins.			
DRUG	DOSAGE (if known)	DRUG	DOSAGE (if known)

Please List Any Surgeries You Have Had			
DATE	SURGERY	DATE	SURGERY

Place a check in the box if you (or family member & list relation) have or have had. If so, give date of occurrence.							
	SELF	DATE	FAMILY		SELF	DATE	FAMILY
Heart Attack				Migraines			
Heart Murmur				Stroke			
Congenital Heart				Epilepsy			
Mitral Valve Prolapse				Tuberculosis			
High Blood Pressure				Asthma			
Bleeding Tendency				Pneumonia			
Blood Disorder				Bronchitis			
Diabetes				Sleep Apnea			
Hepatitis				Pacemaker			
AIDS				Defibrillator			
Leukemia				Bladder Infection			
Stomach Ulcers				Kidney Disease			
Heart Stent				Thyroid Disease			
Arthritis				Cancer			

Do You Smoke? Yes No	If So, How Much?	How Many Years?
Do You Drink? Yes No	If So, How Much?	Do You Drink Over 6 Cups Coffee A Day? Yes No
Taken Steroids? Yes No	If So, When:	Date Last Chest X-Ray:

List Any Serious Illness Or Injuries You Have Had:
REVIEWED & UPDATED:

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