PLASTIC SURGERY CONSULTANTS

# Medical Information Database/Pre-Op Assessment

**Name _____ Date _____**

Reason for seeing Dr. Wassermann _____
Referring Physician _____
Were you seen in the E.R.? YES NO If YES, which hospital _____
Date of accident or injury _____
Primary Care Doctor, Pediatrician, Family Doctor, or GYN, if you have one
_____

## Previous Medical History

**Do you have a latex allergy/Sensitivity? YES NO**
**If YES, what type of reaction _____**

List all known drug allergies: _____
_____

List all medications you are taking and the reason (including Aspirin, Ibuprofen, Motrin, NSAID, Goody Powder, Vitamins, Herbal Medications, etc.) Include dose and frequency.
_____
_____
_____
List any medications you cannot take _____
_____

Accurate Height and Weight_____

## Immunizations

Please indicate date (month and year) of last Immunization

Tetanus Booster _____ Chicken Pox _____
DPT _____ Hepatitis B _____
MMR _____ Polio _____

## Current Medical Problems

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ____ | ____ | High Blood Pressure | ____ | ____ | Cardiac Disease/Heart Attack |
| ____ | ____ | Cancer | ____ | ____ | Diabetes |
| ____ | ____ | Immune Deficiency | ____ | ____ | Kidney Disease |
| ____ | ____ | Lung Disease | ____ | ____ | Substance Abuse |
| ____ | ____ | HIV/AIDS | ____ | ____ | Hepatitis A/B/C |
| ____ | ____ | Breast Disease | ____ | ____ | DVT / PE |

If other, please explain _____

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## Review of Systems

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ____ | ____ | Fever | ____ | ____ | Vision Problems |
| ____ | ____ | Sinusitis | ____ | ____ | Chest Pain |
| ____ | ____ | Seizures | ____ | ____ | Constipation |
| ____ | ____ | Skin lesions that are changing | ____ | ____ | Coughing up blood |
| ____ | ____ | Excessive bleeding/easy bruising | ____ | ____ | Chills |
| ____ | ____ | Glasses | ____ | ____ | Sore Throat |
| ____ | ____ | Shortness of breath | ____ | ____ | Weakness/Numbness |
| ____ | ____ | Sleep Apnea | ____ | ____ | Reflux |
| ____ | ____ | Diarrhea | ____ | ____ | Blood in urine |
| ____ | ____ | Jaundice | ____ | ____ | Weight loss or gain |
| ____ | ____ | Ear aches | ____ | ____ | Wheezing/asthma |
| ____ | ____ | Heartburn | ____ | ____ | Fainting |
| ____ | ____ | Blood in bowel movements | ____ | ____ | Difficulty urinating |
| ____ | ____ | Depression or Anxiety | ____ | ____ | Difficulty healing |

## Previous Hospitalizations

| **Date** (month/year) | Reason for Hospitalization |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## Past Surgical History

| **Date** (month/year) | Procedure | Difficulty with Anesthesia |
|---|---|---|
| _____ | _____ | YES NO |
| _____ | _____ | YES NO |
| _____ | _____ | YES NO |
| _____ | _____ | YES NO |
| _____ | _____ | YES NO |
| _____ | _____ | YES NO |

If medically necessary would you object to a blood transfusion YES NO

Last menstrual period_____ Any chance of being pregnant_____

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## Social History

Do you use tobacco products of any kind? YES NO Amount/Frequency _____

Do you drink alcohol? YES NO Amount/Frequency _____

Do you use illegal drugs? YES NO Amount/Frequency _____

Occupation _____

Living Situation (who is in your household) _____
_____

## Family History

Please X YES or NO and list the relationship

| | YES | NO | Relationship |
|---|---|---|---|
| High Blood Pressure | ____ | ____ | _____ |
| Diabetes | ____ | ____ | _____ |
| Breast Cancer | ____ | ____ | _____ |
| Melanoma | ____ | ____ | _____ |
| Other Cancers | ____ | ____ | _____ |
| DVT / PE | ____ | ____ | _____ |

Date of most recent lab work, EKG, x-ray or diagnostic tests_____
Location_____
Phone_____

Please list the two most important questions we can answer for you at your initial

Consultation:

_____

_____

_____

_____

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NOTES:

TO BE COMPLETED BY OFFICE STAFF:

Pre-Operative:

____ CBC
____ BMP
____ H&H
____ PT
____ PTT
____ UA Pregnancy

____ CXR
____ EKG
____ Other: _____

Orders Mailed to Patient: _____
Order Given to Patient: _____

Reviewed on _____ By _____

Reviewed and Updated on _____ By _____

* Instructed patient to fax results to surgery center: YES NO

Pre-Operative assessment completed by: _____

Date: _____

Anesthesia reviewed by: _____ MD

Date: _____

Patient is approved for outpatient surgery YES NO

ASA I ASAII ASAIII (only with anesthesia consultation)