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, and 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 _____
Covid-19 Dose 1 _____ Covid-19 Dose 2 _____
Covid-19 Booster _____

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

Have you tested positive for Covid-19 within the past year? YES NO

If YES, when was your most recent positive test? _____

Previous Hospitalizations/Pregnancies

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

Would you object to a medically necessary blood transfusion? **YES** **NO**

Last menstrual period_____ Any chance of being pregnant_____

PLASTIC SURGERY CONSULTANTS

Social History

Do you use tobacco/nicotine 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:

_____

_____

_____

_____

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)