Earl Stephenson, Jr., M.D., D.D.S., F.A.C.S.
Certified, American Board of Plastic Surgery

Patient Form: **MEDICAL HISTORY**

Name: ____

Reason for Visit: ____

Height: ______ Weight: ______

PLEASE LIST THE PHYSICIANS CURRENTLY TREATING YOU AND THEIR SPECIALITY

PHYSICIAN NAME	SPECIALITY	PHONE #
____________________	__________________	____________________
____________________	__________________	____________________
____________________	__________________	____________________
____________________	__________________	____________________

PERSONAL HISTORY

DO YOU HAVE or HAVE YOU EVER HAD:

Stroke	NO___ YES___	**Blood Clots/DVT**	NO___ YES___
Heart Disease	NO___ YES___	**Bleeding Problems**	NO___ YES___
High Blood Pressure	NO___ YES___	**Hepatitis**	NO___ YES___
Asthma	NO___ YES___	**Chrohn's Disease**	NO___ YES___
Diabetes	NO___ YES___	**Ulcerative Colitis**	NO___ YES___
HIV/AIDS	NO___ YES___	**Stomach Ulcers**	NO___ YES___
Mental Illness	NO___ YES___	**Kidney Disease**	NO___ YES___

Other____

____

Patient Signature: ______________________________________ **Date**: ____________

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FAMILY HISTORY

DO ANY OF YOU BLOOD RELATIVES HAVE OR EVER HAD:

Diabetes	NO___ YES___
Heart Disease	NO___ YES___
Excessive Bleeding	NO___ YES___
Blood Clots/DVT	NO___ YES___
High Fever after Anesthesia	NO___ YES___
Mental Illness	NO___ YES___
Complication/Bad Reaction to Anesthesia	NO___ YES___

SOCIAL HISTORY

DO YOU SMOKE? NO___ YES___
If yes, HOW LONG?____ HOW MANY PACKS?___

DO YOU USE RECREATIONAL DRUGS? NO___ YES___
If yes, WHAT DRUG(S)?____

DO YOU DRINK ALCOHOL? NO___ YES___
If yes, HOW MUCH AND HOW OFTEN______________________________________

WOMEN ONLY

DO YOU HAVE REGULAR MENSTRUAL CYCLES? NO___ YES___
HOW MANY PREGNANCIES?___________ **HOW MANY LIVE BIRTHS?**__________

HAVE YOU HAD A MAMMOGRAM? NO___ YES___

PAST SURGERIES

____
____
____

Patient Signature: ____ **Date**: ______________

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MEDICATION ALLERGIES

____
____
____

CURRENT MEDICATIONS

MEDICATION NAME	DOSAGE	MEDICATION INSTRUCTIONS

Patient Signature: ______________________________ **Date**: ____________

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WHAT SERVICES INTEREST YOU?

FACE

Facelift_____
Neck Lift_____
Chin Augmentation______
Sliding Genioplasty ______

Otoplasty (ear pining)______
Neck Liposuction______
Brow Lift______
Eyelid Surgery______

Other_________

BODY

Arm Lift_____
Liposuction______
Tummy Tuck_____
Fat Transfer ______

Other_______

BREASTS

Breast Augmentation_____
Breast Lift_____
Breast Reduction______
Breast Revision _____
Other_________

MALE

Gynecomastia _____
Other_________

SKIN

BOTOX®_____
JUVÉDERM®_____
VOBELLA®_____
VOLUMA®______

DPN/Mole Removal______
Chemical Peel_____
Scar Revision_____
Other_________

Patient Signature: ____ **Date**: ______________