Georgia Center
plastic & reconstructive surgery
Joshua R. Groves, M.D.

Patient Name: _____ Birth Date: _____

Patient Height: _____ Patient Weight: _____

Please answer all of the questions as accurately as possible. If you do not understand the question, please ask for assistance.

Who is Your Primary Care Doctor? _____

Drug Allergies: _____Are you allergic to latex? _____

List previous surgeries or major illnesses and dates: _____

_____

List any medications you are taking, including dosage instructions, and medication strength. Be sure to include non-prescription drugs, vitamins, and herbals: _____

_____

Patient's Past Medical History: Have you ever had the following? (Please circle yes or no)

Heart Disease	Yes	No	Cancer	Yes	No	Stomach Ulcer	Yes	No
Arthritis	Yes	No	Glaucoma	Yes	No	Kidney Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Thyroid Disease	Yes	No
Anemia	Yes	No	Aids or HIV	Yes	No	Bleeding Tendency	Yes	No
Tuberculosis	Yes	No	Stroke	Yes	No	Mitral Valve Prolapse ..	Yes	No
Diabetes	Yes	No	Hepatitis	Yes	No	High Blood Pressure	Yes	No

Family History: Has any blood relative ever had the following? (Please circle yes or no)

Breast Cancer	Yes	No	Heart Disease ..	Yes	No	High Blood Pressure	Yes	No
Melanoma	Yes	No	Kidney Disease	Yes	No	Depression	Yes	No
Stroke	Yes	No	Diabetes	Yes	No			

Review of Systems: Do you have now or have you had within the past year? (Please circle yes or no)

Weight Change	Yes	No	Swollen Feet/Ankles	Yes	No	Seizures	Yes	No
Dry Eyes	Yes	No	Skin Rash	Yes	No	Joint or Muscle Pain	Yes	No
Chronic Cough	Yes	No	Chronic Diarrhea	Yes	No	Swollen Lymph Nodes	Yes	No
Chest Pain	Yes	No	Jaundice	Yes	No	Easy Bleeding	Yes	No
Rapid Heart Beat	Yes	No	Depression	Yes	No	Easy Bruising	Yes	No

Social History:

Do you smoke? _____ (type and amount per day) _____If former smoker, date quit: _____

Do you use smokeless tobacco (dip)? _____ Do you drink alcohol? _____

Women Only: **Date of Last Mammogram: _____ Bra Size _____** **(if appointment is breast related)**

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____ _____

Signature of Patient or Guardian **Date**