Gary A. Solomon, M.D., F.A.C.S.

*Plastic Surgery * Cosmetic Surgery*

MEDICAL HISTORY

Name: _____ ❑ Male ❑ Female Age:_____Date of Birth:_____

Reason for Visit: (chief complaint)_____Date of Onset:_____

_____

_____

Do you or have you ever had :

Yes	No		Yes	No		Yes	No	
❑	❑	High Blood Pressure	❑	❑	Bleeding Tendencies	❑	❑	Syncope
❑	❑	Stroke	❑	❑	Anemia	❑	❑	Swollen Glands
❑	❑	Heart Attack	❑	❑	AIDS/HIV	❑	❑	Glasses/Contacts
❑	❑	Irregular Heart beats	❑	❑	Transfusions	❑	❑	Visual Impairment/Dry Eye
❑	❑	Thrombophlebitis/Blood Clots	❑	❑	Diabetes	❑	❑	Cataracts
❑	❑	Rheumatic Fever	❑	❑	Thyroid Problems	❑	❑	Frequent Ear Problems
❑	❑	Chest Pain	❑	❑	Hepatitis/Jaundice	❑	❑	Frequent Nasal bleeding
❑	❑	Shortness of Breath	❑	❑	Kidney Disease	❑	❑	Skin Problem (requiring meds)
❑	❑	Asthma/ Emphysema/Wheezing	❑	❑	Bloody Stool	❑	❑	Mental Illness
❑	❑	Tuberculosis	❑	❑	Bowel Obstruction	❑	❑	Breast Lumps or Discharge
❑	❑	Pneumonia	❑	❑	Stomach Ulcers	❑	❑	Hernia of: _____
❑	❑	Back or Neck Injuries	❑	❑	Bladder Infection	❑	❑	Recent Weight Loss or Gain
❑	❑	Cold Sores/ Herpes	❑	❑	Abnormal X-ray/mammogram			Amount: _____
❑	❑	Sexually Transmitted Disease	❑	❑	Seizures			

❑ ❑ Recent Fractures: WHERE? _____OTHER_____

❑ ❑ Cancer OF/DATE: _____

❑ Mammogram Date: _____ Location: _____

Daily Medications (incl vitamins, herbs, over-the-counter)	Dosage	Daily Medications (incl vitamins, herbs, over-the-counter)	Dosage

❑ Allergies & Side Effects: _____

_____

❑ Operations/Hospitalizations/Cosmetic Procedures (List & Date) _____

_____

PRIMARY CARE DOCTOR: _____Phone# ( )_____Last Exam _____

❑ Family History of Disease:
(List Family Member and Date)

❑ Diabetes_____ ❑ Cancer_____

❑ Stroke_____ ❑ Hypertension_____

❑ Heart Disease_____ ❑ Other_____

DO YOU SMOKE? YES NO NOW IN THE PAST How Much? _____(When Quit) _____

Please Circle One

DAILY ALCOHOL? (Daily Amount): _____

Onset of Last Menstrual Cycle: (date) _____ ❑ Regular ❑ Irregular

Number of Pregnancies:_____ Number of Births:_____ Method of Birth Control:_____**Could you be pregnant now? _____**

I certify that I have disclosed my medical history to the best of my knowledge.

_____ _____/_____/_____

Patient's Signature **Date**