Plastic Surgery Associates of Valdosta
230 Northside Drive, Valdosta, GA 31602
229-242-3002 Phone 229-242-0644 Fax

Patient History

Name: _____ Height: _____ Weight: _____ Date: _____
What is the primary reason for your visit?_____
In case of emergency, contact: _____ Relationship: _____
Home phone: _____Cell phone: _____ Work phone: _____

Name of Primary Physician: _____

How did you learn about Plastic Surgery Associates? (Check one)
_____ Physician Reference. If so, name of Physician _____
_____ Friend, relative or other patient referral. If so, name _____
_____ Phone Book _____ Television Advertisement _____ Other, please specify _____

(ROS) Do you currently have or have you ever had any of the following:

( ) Shortness of Breath	( ) Headaches, dizziness, fainting	( ) Thyroid or goiter
( ) Bruise easily, bleeding problems	( ) Weight gain or weight loss	( ) Nausea, vomiting or bowel problems
( ) Chest Pain	( ) Blurred or impaired vision	( ) Urinary Problems
( ) Heart Palpitations	( ) Chills and/or fever	( ) Night Sweats
( ) Recent sore throat or flu like Symptoms in the last week	( ) Problems with becoming tired and/or upset easily	

(PFSH) Do you currently have or have you ever had any of the following:

( ) Heart Disease	( ) Asthma or lung disease	( ) Kidney disease/stones
( ) High Blood Pressure	( ) Skin Cancer/skin disease	( ) Arthritis
( ) Thyroid or goiter	( ) Ulcers or intestinal problems	( ) Diabetes
( ) Hepatitis or liver disease	( ) Cancer other than skin	( ) Glaucoma ( ) Cataracts

Please provide additional information for any boxes checked above:

_____

Do you have a family history of breast cancer? ( ) No ( ) Yes If yes, who? _____
Have you or any family member ever had a blood clot? ( ) No ( ) Yes If yes, who? _____
Have you or anyone in your family ever been on blood thinners? ( ) No ( ) Yes
Have you or anyone in your family ever been diagnosed with a blood clotting disorder? ( ) No ( ) Yes
Has anyone in your family had a disease called "purpura fulminans"? ( ) No ( ) Yes
Have you ever been diagnosed with lupus or any other autoimmune disease? ( ) No ( ) Yes Name: _____
Have you ever had a miscarriage? ( ) No ( ) Yes

Do you use tobacco? ( ) No ( ) Yes If yes, what type? _____
Do you consume alcoholic beverages? ( ) No ( ) Yes If yes, how often? _____

Are you currently taking any diet pills? ( ) No ( ) Yes Please list _____
Are you allergic to any medications? ( ) No ( ) Yes Please list _____

List all operations/surgeries, injuries, and illness **that have required hospitalization:**

_____

_____

Have you or any relative had a bad reaction to general or local anesthesia? ( ) No ( ) Yes