Stonegate
PLASTIC SURGERY
OF LAKELAND

P: (269) 556-6000
F: (269) 556-6020

3901 Stonegate Park, Ste. 300
St. Joseph, MI 49085

History Intake Form (Page 1 of 2)

Patient Name:______________________________________Birth Date:______________________________

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

Primary Care Doctor: ____

Please list all medical problems/illnesses:

____

____

____

Please list any previous surgeries:

Surgery	**Date**
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________

Past Medical History
Have you ever had the following:

Heart disease........... yes no
Arthritis .... yes no
Rheumatic fever .... yes no
Anemia .... yes no
Tuberculosis............. yes no
Diabetes .... yes no
Cancer .... yes no
Glaucoma .... yes no
Asthma..................... yes no
AIDS or HIV+............. yes no
Stroke .... yes no
Hepatitis................... yes no
Stomach ulcer.................... yes no
Kidney disease .... yes no
Thyroid disease .... yes no
Bleeding tendency .... yes no
Mitral valve prolapse .... yes no
High Blood Pressure........... yes no

Review of Systems
Do you have now or have you had within the last year:

Weight change.......... yes no
Dry Eyes................... yes no
Chronic cough........... yes no
Chest pain................ yes no
Rapid heartbeat........ yes no
Swollen feet/ankles... yes no
Skin rash................... yes no
Chronic diarrhea .... yes no
Jaundice .... yes no
Depression .... yes no
Seizures............................. yes no
Joint or muscle pain........... yes no
Swollen lymph nodes.......... yes no
Easy bleeding/bruising........ yes no
Problems with anesthesia... yes no

Family History
Has any blood relative ever had the following:

Breast Cancer .... yes no
Melanoma .... yes no
Stroke .... yes no
High blood pressure .. yes no
Heart Disease .... yes no
Diabetes .... yes no
Kidney disease .... yes no
Depression......................... yes no
Problems with anesthesia... yes no

Women only:

Age period began ___________________________
Date of last mammogram____________________
Do you do regular breast self-examinations? yes no
Number of pregnancies________________
Did you breast feed? .... yes no
Breast lump or discharge................. yes no

(please continue to page 2)

Reviewed:___________________Date:_____________

Stonegate
PLASTIC SURGERY
OF LAKELAND

P: (269) 556-6000
F: (269) 556-6020
3901 Stonegate Park, Ste. 300
St. Joseph, MI 49085

History Intake Form (Page 2)

Patient Name: ________________________________Birth Date: _________________________________

Weight:___________________ Height: ___________Alcohol(type and amount per week) ______________

Smoking (type & amount per day) ______________________If former smoker, date quit: ______________

Have you ever used "street drugs"?................yes no

Medication List:
Please list all medications you are taking, including non-prescription drugs, vitamins and herbals
(use separate sheet if necessary)

Medication	Dose	How Often

Allergies or Reactions to Medications

Medication	Type of Reaction

I verify that the above information is true and accurate to the best of my knowledge.

X ____ ___________________________________
Signature of patient or parent if minor Date

Would you like your doctor to pray with you before surgery? ____________yes ____________ no

Reviewed:________________________Date:___________

Stonegate
PLASTIC SURGERY
Lakeland Health Affiliate

P: (269) 556-6000
F: (269) 556-6020
3901 Stonegate Park, Ste. 300
St. Joseph, MI 49085

Pre-Op Screening for Malignant Hyperthermia

Have you or anyone in your family ever experienced a high fever while under anesthesia of following anesthesia?

____

Has anyone in your family dies unexpectedly during surgery or exercise? ______________________________

____

Have you or anyone in your family ever been diagnosed with a muscle or neuromuscular disorder?

____

____

Have you or anyone in your family ever experienced a high temperature following exercise?

____

____

Have you or anyone in your family experienced sunstroke, heat stroke, or exercise-induced muscle breakdown resulting in hospitalization?

____

Do you have a personal history of muscle spasms? ______________________________

Have you or anyone in your family ever had dark or chocolate-colored urine following anesthesia or serious exercise?

____

Comments: ______________________________

____

____

____

____

____

Patient Signature: ______________________________ Date: ______________________________

Physician Signature: ______________________________ Date: ______________________________