



Robert Graper, MD FACS
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Reason For Visit

What are your areas of concern?			
<input type="checkbox"/> Body contouring <input type="checkbox"/> Botox <input type="checkbox"/> Breast augmentation <input type="checkbox"/> Breast lift <input type="checkbox"/> Breast reduction	<input type="checkbox"/> Breast reconstruction <input type="checkbox"/> Breast revision <input type="checkbox"/> Breast surgery <input type="checkbox"/> Browlift <input type="checkbox"/> Chemical peel	<input type="checkbox"/> Eyelid surgery <input type="checkbox"/> Faceflift <input type="checkbox"/> Fillers <input type="checkbox"/> Laser <input type="checkbox"/> Lesion	<input type="checkbox"/> Lip augmentation <input type="checkbox"/> Other <input type="checkbox"/> Rhinoplasty
Height/Weight/BMI/BSA			
	Date 1	Date 2	Date 3
Date:	_____	_____	_____
Height (ft):	_____	_____	_____
Height (in):	_____	_____	_____
Weight (lbs) by your scale:	_____	_____	_____
Weight (lbs) per patient:	_____	_____	_____
BMI	_____	_____	_____
BSA	_____	_____	_____
Pregnancy Information			
Number of pregnancies	_____		
Number of child deliveries	_____		
Number of vaginal deliveries	_____		
Number of Cesarean deliveries	_____		
Maximum weight gain	_____		
Patient Smoking History			
<input type="checkbox"/> DENIES <input type="checkbox"/> Denies tobacco use	<input type="checkbox"/> QUIT <input type="checkbox"/> quit <1 year ago <input type="checkbox"/> quit <1-5 years ago <input type="checkbox"/> quit >5 years ago	<input type="checkbox"/> PACKS PER DAY <input type="checkbox"/> <1 pack per day <input type="checkbox"/> 1 pack per day <input type="checkbox"/> 2 packs per day	<input type="checkbox"/> LENGTH <input type="checkbox"/> for <5 years <input type="checkbox"/> for 5-10 years <input type="checkbox"/> for 10-15 years <input type="checkbox"/> for 15-20 years <input type="checkbox"/> for >20 years

Do you have or have had any of the following?

	Yes	No	If yes, please explain
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever been told to take antibiotics prior to dental work?	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skipped heart beats	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack or failure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you seen a cardiologist?	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other blood diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal blood clotting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Jaundice or other liver disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney infections (frequently)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney failure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you born with any nervous system abnormalities?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brain disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spinal cord disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nervous disease (MS, polio, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____

	Yes	No	If yes, please explain
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you wear contacts?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach problems/Bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallbladder problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Female: Do you have regular periods?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Female: Are you going through menopause?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Female: Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Female: Are you planning pregnancy preoperatively?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Female: Have you breast fed in the past 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bridge work in mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crowns or dentures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problem opening mouth wide	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problem turning head	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do any diseases run in your family?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of multiple severe asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of cold sores	<input type="checkbox"/>	<input type="checkbox"/>	_____
Connective tissue disease i.e. RA, SLE	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of immunosuppressive therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had an Aspirin or Motrin (NSAID) like medication in the last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list all medications (including aspirin, vitamins and over-the-counter medications) that you are presently taking. If none, write "none."

Name of Medication	Dosage	Reason for Taking

Please list allergies, if none, please write "none."

Allergy	Reaction
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Previous operations and approximate dates

Type of Operation: _____	_____	_____	_____
Approximate Date: _____	_____	_____	_____
Anesthetic Complications? _____	_____	_____	_____
Treating Doctor: _____	_____	_____	_____
Additional Information: _____	_____	_____	_____

	Yes	No	If yes, please explain
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic reaction to drug used in dental work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood relative with serious allergy to anesthesia drug	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic reaction to drug used with your surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Latex allergy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had a blood clot in your legs or lungs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have prolonged bleeding or trouble clotting your blood?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Additional medical history questions

	Yes	No	If yes, please explain
Have you ever had a complete physical in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had and electrocardiogram in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had a stress test?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Who is your medical doctor? What city?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Verification of Medical History

I completed and verified my above medical history as truly accurate to the best of my knowledge.

Patient Signature: _____ **Date:** _____