LARSON
PLASTIC SURGERY
SURGICAL ART

Name:_____ **DOB:**_____ **Date**:_____

Why are you here to see the doctor? _____

How did you find us?_____

Name and Address of **Primary Physician** or **Referring Physician**: _____
_____

Allergies and reaction: _____
_____

Medications: (include vitamins):
1)_____
2)_____
3)_____
4)_____
If more, please list on back of page

Medical Problems:
1)_____
2)_____
3)_____
4)_____
5)_____

Have you had: (***circle*** all that apply): Heart Issues Heart attack Stroke Pacemaker Stent HIV Trauma Bypass Hospitalization Diabetes High Blood Pressure High Cholesterol Asthma Hepatitis A/B/C Cancer Broken Bones Infection Sepsis Blood Clots Bleeding/Bruising Venereal Disease TB

Previous Surgeries and dates? _____
_____
_____

Family History of Medical Problems? (Cancer, Heart Disease, Hypertension, Stroke etc.) _____
_____

Are you: Married Single Separated Widowed Divorced? Children Y / N? If yes, how many?____
Do you smoke or vape or use nicotine? Y / N if yes, how many cigarettes per day?_____
Do you drink alcohol Y / N If yes how many drinks per day?_____
Do you use recreational drugs Y/N? If yes, what kind and how much?_____
What do you do for a living?_____ For fun?_____

Please ***circle*** any of the following that have been a problem for you recently:

Headache Chest Pain Shortness of Breath Change in Vision, Hearing, Smell, Taste Leg Swelling Nasal problems Fainting Falling Lost Libido Cough Heartburn Incontinence/Leakage Abdominal Pain Nausea Vomiting Fevers Chills Night Sweats Erectile Dysfunction Change in Bowel habits Change in Bladder habits Weight Loss or Gain(_____lbs) Vaginal Laxity New masses New skin lesions Rash Pain(where_____?) Weakness Arthritis Bleeding Bruising Depression Anxiety Memory Loss Mood Swings

Other problems, questions or concerns: _____