



# John E. Gross, M.D.



## Plastic & Reconstructive Surgery

Confidential Record: Information contained herein will not be released except when you have authorized us to do so. Please answer all questions to the best of your Knowledge. The information provided by you will be used by Dr. John Gross in his decision regarding your care.

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Current Weight \_\_\_\_\_ Ideal Weight \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_ Dr. \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone Number \_\_\_\_\_

### DO YOU HAVE OR HAVE HAD: (Circle If Yes, give date of occurrence)

STROKE	NO	YES _____	BLADDER INFECTIONS	NO	YES _____
CANCER	NO	YES _____	ASTHMA	NO	YES _____
TUBERCULOSIS	NO	YES _____	HEART ATTACK	NO	YES _____
LEUKEMIA	NO	YES _____	STOMACH ULCERS	NO	YES _____
BRONCHITIS	NO	YES _____	KIDNEY DISEASE	NO	YES _____
EPILEPSY	NO	YES _____	RHEUMATIC HEART	NO	YES _____
PNEUMONIA	NO	YES _____	BLEEDING TENDENCY	NO	YES _____
DIABETES	NO	YES _____	HIGH BLOOD PRESSURE	NO	YES _____
HEPATITIS	NO	YES _____	CONGENITAL HEART	NO	YES _____
TONSILITIS	NO	YES _____	NERVOUS BREAKDOWN	NO	YES _____
ARTHRITIS	NO	YES _____	MIGRANE	NO	YES _____
HAY FEVER	NO	YES _____	COLITIS	NO	YES _____
GOITER	NO	YES _____	AIDS	NO	YES _____

Do you regularly smoke? NO YES How much? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you regularly drink alcohol or beer? NO YES How Much? \_\_\_\_\_

Do you usually drink over 6 cups of coffee per day? NO YES

Date of Last Chest X-Ray? \_\_\_\_\_

### ARE YOU PRESENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS? (CIRCLE)

ASPIRIN, BUFFERIN, ANACIN	NO	YES	TRANQUILIZERS	NO	YES
BLOOD PRESSURE PILLS	NO	YES	WEIGHT REDUCING PILLS	NO	YES
CORTISONE	NO	YES	BLOOD THINNING PILLS	NO	YES
COUGH MEDICINE	NO	YES	DILANTIN	NO	YES
DIGITAUS	NO	YES	SHOTS	NO	YES
HORMONES	NO	YES	WATER PILLS	NO	YES
INSULIN OR DIABETIC PILLS	NO	YES	ANTIBIOTICS	NO	YES
IRON OR LOW BLOOD MEDICATION	NO	YES	BARBITURATES	NO	YES
LAXATIVES	NO	YES	BIRTH CONTROL PILLS	NO	YES
SLEEPING PILLS	NO	YES	PHENOBARBITAL	NO	YES

THYROID MEDICINE	NO	YES	OTHER DRUGS NOT LISTED	NO	YES
HEADACHE PILLS	NO	YES	_____		
MEDICINE FOR ARTHRITIS	NO	YES	_____		

**DO YOU KNOW OF ANY BLOOD RELATIVE WHO HAS OR HAD: (Circle and give relationship)**

STROKE	NO	YES _____	HIGH BLOOD PRESSURE	NO	YES _____
CANCER	NO	YES _____	BLEEDING TENDENCY	NO	YES _____
SUICIDE	NO	YES _____	STOMACH ULCERS	NO	YES _____
EPILEPSY	NO	YES _____	MIGRAINE	NO	YES _____
TUBERCULOSIS	NO	YES _____	ASTHMA	NO	YES _____
DIABETES	NO	YES _____	HIGH FEVER AFTER SURGERY	NO	YES _____
LEUKEMIA	NO	YES _____	HEART ATTACK	NO	YES _____
KIDNEY DISEASE	NO	YES _____	ARTHRITIS	NO	YES _____
GIOTER	NO	YES _____	HAY FEVER	NO	YES _____
COLITIS	NO	YES _____	NERVOUS BREAKDOWN	NO	YES _____
RHEUMATIC HEART	NO	YES _____	INSANITY	NO	YES _____
CONGENITAL HEART	NO	YES _____	ANESTHESIA COMPLICATIONS	NO	YES _____

Write in the names and years of any operations which you have had: \_\_\_\_\_

Name any drugs to which you are allergic: \_\_\_\_\_

Serious illnesses which you have had: \_\_\_\_\_

Serious injuries or accidents: \_\_\_\_\_

Do you take aspirin regularly? NO YES How often? \_\_\_\_\_

Do you have nose bleeds? NO YES How often? \_\_\_\_\_

Do you frequently have bleeding gums? NO YES

Have you ever bled excessively from a tooth extraction? NO YES

**WOMEN ONLY:**

Are you still having regular monthly periods? NO YES

Have you ever had bleeding between you periods? NO YES When? \_\_\_\_\_

Do you have very heavy bleeding with your periods? NO YES When? \_\_\_\_\_

Are you now on or have taken birth control pills? NO YES When? \_\_\_\_\_

Have you ever had nipple discharge? NO YES When? \_\_\_\_\_

Have you had a mammogram? NO YES When? \_\_\_\_\_ Where? \_\_\_\_\_

How many pregnancies? \_\_\_\_\_ How many children born alive? \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

**MEN ONLY:**

Hernia (rupture)? NO YES

Prostate Trouble? NO YES