CANNON
Plastic & Reconstructive Surgery

PATIENT HISTORY

First Name	MI	Last Name	Date of Birth	Age

Address	City	State	Zip Code

Home Number	Mobile Number	Other Contact Number

Emergency Contact	Emergency Contact Number

If consultation is related to an injury, date of injury	
Was the injury related to: work, car accident or assault?Please explain.	
Name of hospital and date you were seen regarding injury	
Name of physician who referred/ treated you	

Primary/Family Physician	

Personal Medical History					
Abnormal Bleeding	☐ Y ☐ N	Asthma	☐ Y ☐ N	Hypertension	☐ Y ☐ N
Abnormal Clotting	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Sleep Apnea	☐ Y ☐ N
Acid Regurgitation	☐ Y ☐ N	Heart Attack	☐ Y ☐ N	Hyperlipidemia	☐ Y ☐ N
Anemia	☐ Y ☐ N	Heart Failure	☐ Y ☐ N	Scarring/Keloid	☐ Y ☐ N
Angina	☐ Y ☐ N	Hepatitis	☐ Y ☐ N	Stroke	☐ Y ☐ N

Other Medical Illness	

Surgical History (Type of Procedure and Year Performed)	

Have you ever had:			
Local Anesthesia	☐ Y ☐ N	General Anesthesia	☐ Y ☐ N
List any complications/reactions you experienced to any/all anesthesia or surgery			

Review of Symptoms - Please circle any of the following that you have experienced.

General
weight change
sleep changes
appetite change
fatigue
fever/chills

Head
headache
head injury

Eyes
vision change
blurriness/double vision
pain
redness
flashing lights
glaucoma
cataracts

Ears
decreased hearing
ringing
earache
discharge

Nose
stuffiness
discharge
itching
hay fever
nosebleeds
sinus pain

Throat
problems with teeth or gums
dry mouth
sore throats
hoarseness

Neck
lumps
swollen glands
pain
stiffness

Skin
rashes
bruising
lumps
itching
dryness
color change
change in hair or nails
delayed healing
disfigured scarring
thickened scarring
keloid formation

Neurological
dizziness
lightheadedness
fainting
seizures
weakness
paralysis
numbness
tingling

Endocrine
heat or cold intolerance
excessive sweating
excessive urination
change in glove or shoe size

Respiratory
cough
sputum
blood
difficulty breathing
wheezing
pain
TB exposure
Pulmonary Embolus

Cardiovascular
chest pain
tightness
palpitations
leg edema

GI
trouble swallowing
appetite change
nausea
heartburn
bloody stool
constipation
diarrhea
pain
jaundice
tarry stools
change in bowels

GU
frequency
night urination
urgency
burning
blood in urine
infections
kidney stones,
incontinence
hesitancy

Blood
claudication
leg cramps
varicose veins
blood clots (DVT)
easy bruising
easy bleeding
anemia
history of transfusion

Musculoskeletal
muscle or joint pains
stiffness
gout
back pain
swelling

Psych
nervousness
depression
memory loss
stress
eating disorder
body dysmorphic disorder
ADHD
bipolar

Sex	Occupation/Employer	Marital Status (Circle One)
☐ MALE ☐ FEMALE		Married / Single / Divorced

Smoke	
☐ Y ☐ N **Amount** (Per day and number of years)	**If quit, how long ago:**

Alcohol
☐ Y ☐ N **Amount**

Exercise
☐ Y ☐ N **Amount**

Illicit Drugs
☐ Y ☐ N **Type**

Medications Prescriptions / Non-Prescription Supplements (vitamins, herbs, etc.)	

Regular Aspirin/Coumadin/Lovenox/Plavix	☐ Y ☐ N	**Have you ever taken Accutane?**	☐ Y ☐ N
NSAID (Advil, Motrin, Ibuprofen)	☐ Y ☐ N	**Taken steroids in the last year?**	☐ Y ☐ N

Allergies Please list all allergies and type of reaction.	

Drug Allergy ☐ Y ☐ N	**Latex Allergy** ☐ Y ☐ N	**Tape Allergy** ☐ Y ☐ N

Family Medical History			
Abnormal Bleeding	☐ Y ☐ N	**Asthma**	☐ Y ☐ N
Abnormal Clotting	☐ Y ☐ N	**Diabetes**	☐ Y ☐ N
Anesthesia Problems	☐ Y ☐ N	**Heart Attack**	☐ Y ☐ N
Cancer	☐ Y ☐ N	**Hypertension**	☐ Y ☐ N
Please Describe any other illness in your family:			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inaccurate information can be dangerous to my health.

Patient Signature: _____ Date: ____/____/____

Cliff Cannon III, MD: _____ Date: ____/____/____