PRE-OPERATIVE INFORMATION

Have you ever had a bad or adverse reaction to anesthesia?	**Yes**	**No**	**Are you allergic to adhesive tape?**	**Yes**	**No**
Are you allergic to suture material?	**Yes**	**No**	**Do you bruise easily?**	**Yes**	**No**
Do you have high blood pressure (hypertension)?	**Yes**	**No**	**Do you bleed unusually easily?**	**Yes**	**No**
Have you ever had rheumatic fever?	**Yes**	**No**	**Are you a slow or poor healer?**	**Yes**	**No**
Do you have frequent infections or "boils"?	**Yes**	**No**	**Do you form large scars or keloids?**	**Yes**	**No**
Have you taken steroids (Cortisone) medications?	**Yes**	**No**	**Do you have any skin disease?**	**Yes**	**No**
Do you have shortness of breath after walking?	**Yes**	**No**	**Have you ever had psychiatric care?**	**Yes**	**No**
Does your religion prohibit blood transfusion?	**Yes**	**No**	**DO YOU SMOKE?**	**Yes**	**No**
Have you ever tested positive for AIDS or HIV?	**Yes**	**No**			

_____ **_____ Date _____/_____/_____**

Signature **Relationship to Patient**

PHYSICAL EXAMINATION (To be completed by Dr. Webster or nurse)

Pulse _____ Blood Pressure _____ Height _____ Weight _____ Temperature _____

HEENT _____

_____

NECK: **Masses _____ Trachea _____ Thyroid _____**

Clear _____ Rhonchi _____ Wheezes _____

Prolonged Expiration _____

BREASTS: _____

_____

HEART: **Murmurs _____ Thrills _____ Rhythm _____**

ABDOMEN: **Organomegaly _____ Masses _____ Tenderness _____**

SKIN: _____

EXTREMITIES: _____

NEURO: _____

PLAN: _____

IMPRESSION: _____

_____

_____

Signature

Date _____ Time _____

H & P Reviewed prior to surgery/procedure, no changes in physical status.

Signature _____ Date _____ Time _____

Oklahoma Plastic Surgeons
3705 Northwest 63rd Street, Suite 204
Oklahoma City, Oklahoma 73116

HISTORY AND PHYSICAL EXAMINATION

(PLEASE PRINT)

Date _____

Patient Name _____ **Age** _____ **Date of Birth** _____/_____/_____

Occupation _____ **Referred By** _____

Present Problem (Reason for consultation with Dr. Webster) _____

_____

Date of Last Physical/Medical Examination _____/_____/_____ **Physician** _____

Date of Last Mammogram _____/_____/_____ **Location (Mammography Facility)** _____

Date of Last Electrocardiogram (EKG) _____/_____/_____ **Date of Last Chest X-Ray** _____/_____/_____

MEDICAL/SURGICAL HISTORY

Procedure	Date	Surgeon

Did you have any significant side effects or complications as a result of the surgical procedure listed above? Yes ____ No ____
If so please explain:
_____

Please list all of your current medications:

_____ _____

_____ _____

Please list any KNOWN DRUG ALLERGIES: _____

Please list any serious illness or health problems you have or have had in the past: _____

_____

Please circle any illnesses you have or have had in the past of the following organ systems:

Brain (including stroke or epilepsy)	**Face (including paralysis)**	**Intestines**
Lungs (including asthma)	**Nose, Sinus, Throat**	**Blood**
Endocrine or Diabetes	**Arms or Legs**	**Ears**
Heart or Blood Vessels	**Nervous System**	**Liver**
Eyes (including Glaucoma or dryness)	**Breasts**	**Stomach**
Reproductive System	**Urinary System**	**Bones or Joints**

Please explain any problems you have or have had in the past with the conditions circled above:

_____

_____

FAMILY HISTORY

Has anyone in your immediate family had any of the following medical conditions? (Please circle)

Cancer	**Heart Disease**	**High Blood Pressure (Hypertension)**	**Epilepsy**	**Diabetes**
Tuberculosis (TB)	**Kidney Disease**	**Blood or Bleeding Disorder**	**Lung Disease**	

(Continued on back)

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