

ALLEGANY PLASTIC SURGERY

DR ROBERT J CARPENTER

For office use only:

Name _____

Age _____ Height _____ Weight _____

Smoker YES / NO

Any Current Medications:

(Prescription, Vitamins, Herbal & Over the Counter)

Allergies: _____

Previous Surgery/Procedure & Date : _____

Family History:

Has any blood relative ever had any of the following:

Breast cancer..... yes no High Blood Pressure.....yes no Kidney Diseaseyes no
Melanomayes no Heart disease.....yes no Depressionyes no
Strokeyes no Diabetesyes no

Past Medical History:

Have you ever had the following:

Heart Diseaseyes no Cancer..... yes no Stomach Ulcer.....yes no
Arthritisyes no Glaucoma yes no Kidney Disease ...yes no
Rheumatic Fever.....yes no Asthma..... yes no Thyroid Disease...yes no
Anemiayes no AIDS or HIV+..... yes no Bleedingyes no
Stroke... yes no High Blood Pressure. yes no Tuberculosisyes no
Diabetes.....yes no Hepatitis.....yes no

Review Of Systems:

Do you have now or have you had within the past year:

Weight Change.....no yes Swollen feet/ankles.....no yes Seizures..... no yes
Dry eyesno yes Skin rashno yes Joint/Muscle Pain...no yes
Chronic coughno yes Chronic diarrheano yes Swollen lymph nodes ...no yes
Jaundiceno yes Easy Bleedingno yes Chest painno yes
Rapid Heart Beatno yes Depressionno yes Easy Bruisingno yes

Women only: Date of last mammogram _____ Breast lump or discharge _____

Reason For this visit: _____

Date Of Injury: _____ Date of First Symptom _____ Work Related: Yes/ No

X _____
Signature of Patient or parent if minor Date Signature of Dr Robert J Carpenter

****If you have any questions or need any assistance in filling out this form our staff will assist you****