PLASTIC SURGERY CENTER Of Hattiesburg

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40 Franklin Road
Hattiesburg, MS 39402
Phone (601) 296-3405 · Fax (601) 296-3409

REVIEW OF SYSTEMS

Patient Name: DOB:

- ☐ Ever had Anemia (low blood)
- ☐ Abnormal bleeding or ☐ bruising tendencies
- ☐ Enlarged or ☐ painful glands (lymph nodes)
- ☐ Excessive thirst or ☐ excessive urination
- ☐ Any skin problem that concerns you
- ☐ Pain, ☐ swelling, or ☐ redness of joints?
  Where _____
- ☐ Pain or discomfort in your ☐ neck, ☐ spine, or ☐ back
- ☐ Lightheadedness, ☐ dizziness, or ☐ vertigo
- ☐ Loss of consciousness, ☐ "passing out", or ☐ fainting
- ☐ Headaches which are a problem for you
- ☐ Hearing impaired or deafness
- ☐ Stuffy nose, ☐ postnasal drip, or ☐ sinus attacks
- ☐ Persistent or recurrent cough
- ☐ Problems with gums, ☐ mouth, or ☐ teeth
- ☐ Wear dentures
- ☐ Any neck pains or ☐ lumps

- ☐ Shortness of breath during exercise or walking
- ☐ Spells of difficult or ☐ uncomfortable breathing
- ☐ Bothered with wheezing or ☐ asthma
- ☐ Persistent or ☐ chronic cough
- ☐ Ever coughed up blood

- ☐ Chest pains
- ☐ Awaken at night with smothering spells
- ☐ Sleep propped up in bed or ☐ with head elevated
- ☐ Palpations, ☐ skipping, or ☐ racing heart
- ☐ Ever have a heart murmur

- ☐ Any change in your appetite recently? ☐ More ☐ Less
- ☐ Any trouble with heartburn, ☐ indigestion, ☐ gas?
- ☐ Any trouble swallowing food or ☐ liquid?
- ☐ Spells of nausea or ☐ vomiting?
- ☐ Ever vomit blood or ☐ coffee ground material?
- ☐ Ever had yellow jaundice, ☐ Hepatitis, or ☐ HIV (AIDS)?
- ☐ Bowel habits change in the last 6 months
- ☐ Problems with diarrhea or ☐ constipation
- ☐ Rectal pain or ☐ pain with bowel movements
- ☐ Ever had black, ☐ tarry, or ☐ bright red blood in your stools?

- ☐ Ever had tremors or ☐ uncontrolled shaking
- ☐ Any tingling, ☐ burning, or ☐ shooting pains of extremities?
- ☐ Any trouble sleeping

- ☐ Any breast lumps or tenderness

List below any additional problems you would like to discuss with the doctor today:

_____

_____

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____

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MEDICAL HISTORY RECORD

Name: _____ Date of Birth: _____

Height _____ Weight: _____ Age: _____

Referred By: _____

Reason for visit: _____

Date symptoms first appeared: _____

PERSONAL MEDICAL HISTORY (Check Yes or No)

☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No	Fainting or blackouts
☐ Yes	☐ No	Heart attack or disease	☐ Yes	☐ No	Ulcers
☐ Yes	☐ No	Heart murmur	☐ Yes	☐ No	Hepatitis
☐ Yes	☐ No	Chest pain or shortness of breath	☐ Yes	☐ No	Diabetes (sugar)
☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Other: _____

SURGERIES:

_____

_____

SOCIAL HISTORY (Check Yes or No)

☐ Yes ☐ No Do you smoke? _____ packs per day

☐ Yes ☐ No Do you drink alcohol or beer?

CURRENT MEDICATIONS List all including aspirin, birth control, and herbal supplements.

Medication	Dose/Strength	Frequency taken

ALLERGIES:

Medication	Reaction when taken

BLEEDING/TRANSFUSION HISTORY (Check Yes or No)

☐ Yes ☐ No Have you taken ibuprofen/aspirin in the past two weeks?

☐ Yes ☐ No Have you had a blood transfusion?

☐ Yes ☐ No Have you ever been tested for HIV (AIDS)?

☐ Yes ☐ No Have you ever had MRSA (Staph)?

SCARRING

☐ Yes ☐ No Have you formed excessive or unsatisfactory scars in the past?

FAMILY HISTORY Is there a history of the following in your immediate family? If so, list family member beside the disease

☐ Yes	☐ No	Any anesthetic problems _____	☐ Yes	☐ No	Hepatitis _____
☐ Yes	☐ No	High blood pressure _____	☐ Yes	☐ No	Heart Attack _____
☐ Yes	☐ No	Diabetes _____	☐ Yes	☐ No	Cancer (skin) _____
☐ Yes	☐ No	Stroke _____	☐ Yes	☐ No	Cancer _____

Patient Signature: _____ Date: _____

Reviewed: _____ Date: _____