THE CENTER
for Plastic Surgery & Skin Care
231.929.7700

DATE

REVIEW OF SYSTEMS

Patient Name

Patient DOB

Any known allergies? Yes No
Currently taking any medications? Yes No
Previous problems with anesthesia? Yes No
Please explain the reason for your appointment today:

Please list all surgical procedures performed:

List all medical allergies:

LIST ALL OF YOUR MEDICATIONS (INCLUDE SUPPLEMENTS):

SKIN CARE PATIENTS

Have you ever taken or are currently taking (circle all that apply): Retin A Accutane Tretinoin Differin (in the last 3 months)

Have you ever used an over-the-counter or prescription bleach cream? Yes No

Do you take Topical or Oral Antibiotics (circle all that apply): Oral Topical What is the name of the Antibiotic?

How much UV exposure do you get (sun, tanning beds, commuting in car)?

Have you ever received any of the following treatments (circle all that apply): Facial Microdermabrasion Laser Surgery

Chemical Peels Waxing Lash/Brow Tint Laser Hair Removal Vein Treatments Botox/Filler

When did this (these) procedure(s) take place?

Any allergic reaction? Specify:

Please select the statement that applies to you (circle one): I never tan, always burn. I tan with difficulty, usually burn.

I'm an average tanner, sometimes burn. I easily tan, rarely burn. I never burn.

Please indicate if you are currently experiencing or have a history of any of the following conditions:

Weakness ..... Yes No
Fatigue ..... Yes No
Fever ..... Yes No

Glasses or contact lenses ..... Yes No
Change in vision ..... Yes No
Pain in eyes ..... Yes No
Redness of eyes ..... Yes No
Excessive tearing ..... Yes No
Double vision ..... Yes No
Glaucoma ..... Yes No
Cataracts ..... Yes No
Date of last eye exam ____ / ____ / ____

Have you had an EKG? ..... Yes No
Date of EKG ____ / ____ / ____
Heart Attack ..... Yes No
High blood pressure ..... Yes No
Heart murmur ..... Yes No
Chest pain or discomfort ..... Yes No
Irregular heartbeat ..... Yes No

Rheumatic fever ..... Yes No
Shortness of breath ..... Yes No
Swollen ankles ..... Yes No

Chronic cough ..... Yes No
Diabetes ..... Yes No
Wheezing ..... Yes No

Asthma ..... Yes No
Bronchitis ..... Yes No
Emphysema ..... Yes No
Pneumonia ..... Yes No
Tuberculosis ..... Yes No
COPD ..... Yes No

Joint stiffness ..... Yes No
Arthritis ..... Yes No
Gout ..... Yes No
Backache ..... Yes No
Nausea/vomiting ..... Yes No

Change in bowel habits ..... Yes No
Rectal bleeding ..... Yes No
Constipation/diarrhea ..... Yes No
Chronic abdominal pain ..... Yes No
Jaundice ..... Yes No
Liver trouble ..... Yes No
Gallbladder trouble ..... Yes No
Hepatitis ..... Yes No
Ulcers ..... Yes No

Non-healing sores ..... Yes No
Changes in hair and/or nails ..... Yes No

Breast lump ..... Yes No
Breast pain or discomfort ..... Yes No
Nipple discharge ..... Yes No

Do you perform breast self-exams? Yes No
Date of last mammogram ____ / ____ / ____

Age of first menstrual cycle ____
Regular menstrual cycles ..... Yes No
Number of pregnancies ____
Number of deliveries ____

Neurological disorders ..... Yes No
Psychiatric disorders ..... Yes No
Endocrine disorders ..... Yes No
Anemia ..... Yes No
Hormonal disorders ..... Yes No

Hearing problems ..... Yes No
Tinnitus/ringing in the ears ..... Yes No
Dizziness ..... Yes No
Ear infection ..... Yes No

Tobacco use ..... Yes No
How much
Alcohol use ..... Yes No
How much
Recreational drug use ..... Yes No
How much
Caffeine use ..... Yes No
How much