The J. Parry Clinic
for Facial Plastic Surgery & Aesthetics

MEDICAL HISTORY

PATIENT INFORMATION							
FIRST:		MI:		LAST:		DOB:	
Date:		Age:		Height:		Weight:	

Primary Care Physician: _____

Referring Physician/Office: _____

Why are you seeing the doctor today? _____

When did the problem begin? _____

Medications (Including Vitamins and Herbal Supplements): **Patients are encouraged to bring their medication bottles with them to each appointment**	
Medication	Dosage

Previous Surgeries			
Type	Date	Type	Date

PHARMACY INFORMATION			
PHARMACY NAME:		PHONE NUMBER:	
ADDRESS:			
MAIL AWAY PHARMACY:	:		

>>>>>>>> Please complete both sides of form. Thank you. <<<<<<<<

MEDICAL HISTORY

Medical History / Review of Systems			
☐ Anemia	☐ Stomach Ulcer	☐ Connective Tissue Disorder	
☐ Bipolar Disorder	☐ TIA	☐ Heart Valve Disease	☐ Fibromyalgia
☐ Psoriasis	☐ Thyroid Disease	☐ Irregular Heart Beat	☐ Fracture
☐ Frequent Rash	☐ Seizure Disorder	☐ Heart Attack	☐ Incontinence
☐ Weight Gain	☐ Emphysema	☐ Chest Pain	☐ Kidney Failure
☐ Weight Loss	☐ COPD	☐ High Cholesterol	☐ Kidney Stones
☐ Poor Vision	☐ Parkinson's Disease	☐ Blood Transfusion	☐ Osteoarthritis
☐ Hearing Loss	☐ Sickle Cell Disease	☐ Pacemaker/Defibrillator	☐ Osteoporosis
☐ Fever	☐ Asthma	☐ High Blood Pressure	☐ Painful Urination
☐ Diarrhea	☐ HIV/AIDS	☐ Infection After Surgery	☐ Pregnant
☐ Skin Ulcers	☐ Hepatitis	☐ Heart Burn	☐ Prostate Disease
☐ Depression	☐ Stroke	☐ Bleeding Disorder	☐ Rheumatoid Arthritis

Are you taking, or have you ever taken, blood thinners? ☐ Yes ☐ No

Stomach pain when taking anti-inflammatories? ☐ Yes ☐ No

Diabetes? ☐ Yes ☐ No Controlled with: ☐ Diet ☐ Oral Medications ☐ Insulin

History of blood clots? ☐ Yes ☐ No ☐ Leg ☐ Lung ☐ Other_____

Cancer history_____

Treatment(s) _____

Other medical history **not** listed above_____

List any problems with anesthesia_____

Social History			
☐ Work Full Time	☐ Work Part Time	☐ Unemployed	☐ Retired
Occupation: _____			
Living Arrangements:	☐ Live Alone	☐ Live w/ Spouse	☐ Live w/ Parents
☐ Nursing Home	☐ Live w/ Children	☐ Other: _____	
Alcohol Consumption:	☐ Never	☐ Rarely	☐ Socially
☐ Moderately	☐ Heavy	☐ Recovering	
Smoking:	☐ Never	☐ Formerly	☐ Presently
How many packs per day?			

To the best of my knowledge all the preceding answers are true and correct. If I have any change in my medical history, I will inform The J. Parry Clinic for Facial Plastic Surgery & Aesthetics at my next appointment, or by phone if no visits are scheduled. I understand that failure to disclose my medical condition may jeopardize my health.

Patient's Signature: _____ Date: _____

(Parent/Legal guardian if patient is a minor