

W. Stanford Blalock, M.D., PLC

Plastic & Reconstructive Surgery

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Date _____

PATIENTS MEDICAL HISTORY

1. Full Name: _____ Birth Date: _____ Age: _____
2. Describe briefly your reason for coming to our office:(date of injury if applicable) _____

GENERAL HEALTH

1. Are you allergic to any foods? Yes No
If so, list foods & type of reaction: _____
2. Are you allergic to any medications? Yes No
If so, list medication & type of reaction: _____
3. Do you have any other allergies such as creams, tape, latex, etc.? Yes No
If so please list _____

CURRENT MEDICATIONS

(Include herb, vitamins, & any other over-the-counter medication. Provide a separate sheet if necessary)

MEDICATIONS	STRENGTH	DOSAGE	PURPOSE

Do you bruise or BLEED EASILY Yes No

Do you take aspirin regularly Yes No

PAST MEDICAL HISTORY

4. Are you being treated for any health problems now or have you been treated within the past five years? Yes No
If so, what type of illness? _____

5. Have you ever been treated for one of the following:

Yes No Year

Yes No Year

	Yes	No	Year		Yes	No	Year
Diabetes				Thyroid Problem			
Tuberculosis				HIV/AIDS			
Kidney Disease				Liver Disease or Hepatitis			
High Blood Pressure				Blood or Bleeding Problems			
Heart or Circulatory Disease				Cancer			
Heart Attack				Arthritis			
Lung problem or pneumonia				Epilepsy or seizures			

Please continue form on reverse side

6. Do you ever:

Yes No

Yes No

Cough up blood			Have stomach problems		
Vomit up blood/blood in stools			Feel faint or dizzy		
Have shortness of breath			Have nose problems (runny or stuffy)		
Have chest pain			Have dry eyes		
Have heart palpitations			Have problems with your vision		
Have skin disorders/problems with healing					

Please explain all yes answers:

7. Please list any operations you have had, including dates:

8. Have you had any major injuries? Yes No When _____ How injured _____

_____ Nature of Injury _____

9. When was your last mammogram? _____

10. When was your last EKG? _____

11. Have you ever been under care for psychological or emotional problems? Yes No If yes please describe:

12. Present weight _____ Weight one year ago _____ Best weight for you _____ Height _____

SOCIAL HISTORY

1. Marital Status: _____

2. How many children do you have? _____

3. Tobacco use Yes No Smoke Chew How much per day? _____

When did you start? _____ If you smoked in the past when did you quit? _____

How many years did you smoke? _____

4. What type of work do you do? _____

5. Do you drink alcohol? _____ How much and how often _____ When was your last drink? _____

FAMILY HISTORY

Are there any illness or cancer that runs in your family?

Please provide details: _____
