GALLAHER
GALLAHER PLASTIC SURGERY & SPA MD

HISTORY AND PHYSICAL

PATIENT NAME: _____ **DATE:**_____

PREFERRED PHARMACY NAME, ADDRESS AND PHONE NUMBER: _____

_____

AGE: _____ **HEIGHT:** _____ **WEIGHT:** _____

The following questions are to be filled out by the patient. Check box **YES** or **NO**.
Any positive response will be discussed with you by your doctor.

LUNGS	**YES**	**NO**
COPD	☐	☐
Cough or Fever at present time	☐	☐
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Lung cancer	☐	☐
Do you smoke	☐	☐
If yes,_____packs of cigarettes per day for the past_____years.		

HEART		
Heart disease	☐	☐
Heart murmur	☐	☐
High blood pressure	☐	☐
Skipped heart beats	☐	☐
Chest pain	☐	☐
Hardening of the arteries	☐	☐
Heart failure	☐	☐
Heart attack	☐	☐
Rheumatic fever	☐	☐

BLOOD		
Bruise or bleed easily	☐	☐
Abnormal bleeding in family	☐	☐
Sickle cell trait/disease	☐	☐
Other blood cell disease	☐	☐
Prolonged bleeding with tooth extraction	☐	☐

LIVER		
Drink alcoholic beverages	☐	☐
Hepatitis	☐	☐
Jaundice	☐	☐
Other liver disease	☐	☐

KIDNEY		
Born with kidney disease	☐	☐
Kidney infections	☐	☐
Kidney stones	☐	☐
Any history of mental illness?	☐	☐

NERVOUS SYSTEM	**YES**	**NO**
Abnormality of nervous system	☐	☐
Brain disease	☐	☐
Spinal cord disease	☐	☐
Nerve disease	☐	☐
Epilepsy	☐	☐
Stroke	☐	☐

ENDOCRINE		
Diabetes Type 1____ Type 2_____	☐	☐
Thyroid disorder	☐	☐

EYE		
Glaucoma	☐	☐
Contact lenses	☐	☐

STOMACH, BOWEL, GALL BLADDER		
Any stomach disease	☐	☐
Bowell disease	☐	☐
Gall Bladder disease	☐	☐

AIRWAY		
Problems opening mouth wide	☐	☐
Problems turning head in any direction	☐	☐

REPRODUCTIVE		
Are you pregnant?	☐	☐
Planning pregnancy preoperatively?	☐	☐
Have you breast fed in last 3 months	☐	☐
Diseases of the reproductive system?	☐	☐
Children?	☐	☐

MUSCULOSKELETAL		
Joint damage/injury	☐	☐
Tendon damage/injury	☐	☐
Nerve damage/injury	☐	☐

THIS FORM MUST BE COMPLETED FRONT AND BACK.

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Do you have any past or present health problems not indicated above? If yes, please describe: _____

Do any diseases run in your family? If so, name them:

SURGICAL HISTORY: List previous operations and approximate dates: _____

	YES	NO
Complications after surgery?	☐	☐
Bleeding or blood clot(s)?	☐	☐
Infection?	☐	☐

Other: _____

ANESTHETIC HISTORY	YES	NO
Any problems resulting from local or general anesthetic administered to you?	☐	☐
Nausea and/or vomiting?	☐	☐
Any family members with problems related to anesthesia?	☐	☐

Date of last general anesthetic: _____

If you answered yes to any of the above anesthetic questions, please explain:

DRUG ALLERGIES (List): _____

What kind of reaction? _____

Who is your primary care physician?

_____ Phone#: _____

LIST ALL PRESENT MEDICATIONS by name and the reason for taking them. Especially important are: Cortisone, hormones or birth control pills, cold medications, aspirin or aspirin-containing medications, tranquilizers, sedatives, antidepressants, blood thinners (anticoagulants), heart medications, and water pills (diuretics).

Any history of Arthritis? _____

If so, type of Arthritis: _____

If you are taking Arthritis medication, please list: _____

Name of the physician treating Arthritis:

List any vitamins and/or herbal supplements you are presently taking:

Any other disclosures you feel may be important:

Patient's Signature _____ Date: _____