



Advanced Surgery Center- Founders' Circle
1947 Founders' Circle
Wichita, KS 67206
(316) 613-4707

Advanced Aesthetics by Wichita Clinic
9211 East 21st Street North
Wichita, KS 67206
(316) 609-4440



Plastics History Form

This is a confidential record and will be kept in your Advanced Aesthetic chart only.
Information will not be released without your authorization.

Today's Date: _____ MRN _____ Date of Birth: ___/___/___

Full Name: _____ Patient Social Security #: ___/___/___

Street Address: _____ City/State: _____ Zip Code: _____

Sex: M _____ F _____ Patient's Home Phone: (____) _____ Daytime Phone: (____) _____

E-mail Address: _____

How did you hear about us?

Website Family/Friend Newspaper Women's Fair Magazine Phone Book Physician Referral

Other (Please explain): _____

Employer: _____ Occupation: _____

Reason for today's visit? _____

When did you first notice this? _____ How long does it last? _____

Does anything make it worse? _____ Does anything make it better? _____

Have you had any of the following health problems in the past?

- Cancer
- Spinal injury
- Diabetes
- Thyroid condition
- Epilepsy
- Varicose veins
- Heart problems
- Systemic disease
- Hormone Imbalance

Past Medical History: Please list any other medical conditions (high blood pressure, stroke or heart attack, ulcers, etc.)

Past Surgical History: Please list any previous surgical procedures and dates performed:

Procedure Year

Medications: Please list any medications you currently take (including prescribed, over-the-counter, Herbal, supplements):

Name of medication Dosage (mg/strength) # times per day

Name of medication	Dosage (mg/strength)	# times per day

Allergies: Please list all allergies to medications:

Medication Reaction

Have you had an operation where any bleeding or anesthetic complications occurred? Yes No

If yes, please explain: _____

Family History: Please list any serious conditions that run in your family:

Social History:

Do you smoke? Yes No

If so, maximum number of packs per day? _____

For how many years? _____

Do you consume alcohol? Yes No

If so, list alcohol amount and frequency: _____



Medical History Form – Review of Systems

Do you now, or have you had any problems related to the following body systems? Please check yes or no, and explain in the space provided.

General Symptoms:			Comments	Skin:			
Yes	No	Yes		No	Comments		
Fever				Rash			
Chills				Boils			
Weight loss				Itching			
Vision / Eyes:			Comments	Musculoskeletal:			
Yes	No	Yes		No	Comments		
Blurring				Joint pain			
Doubling				Neck pain			
Blindness				Back pain			
Allergy / Immune:			Comments	Ear-Nose-Throat:			
Yes	No	Yes		No	Comments		
Hay fever				Infection			
Drug allergy				Sinus problem			
Latex				Snoring			
Other							
Neurologic:			Comments	Genitourinary:			
Yes	No	Yes		No	Comments		
Tremors				Incontinence			
Dizziness				Painful void			
Numbness				Frequency			
Stroke				Difficulty			
TIA							
Gastrointestinal:			Comments	Respiratory:			
Yes	No	Yes		No	Comments		
Abdominal pain				Wheezing			
Nausea				Persistent cough			
Vomiting				Short of breath			
Heartburn				Winded easily			
Appetite loss							
Bloody stool							
Heart:			Comments	Blood / Lymph:			
Yes	No	Yes		No	Comments		
Chest pain				Easy bruising			
Heart attack				Bleeding			
Palpitations				Blood clots			
Passing out				Swollen glands			
Psychological:			Yes	No	Comments		
Are you satisfied with life?							
Are you depressed?							
Have you been suicidal?							
Physician use: (Comments / Notes)							