



Plastic Surgical Arts
1730 S. 70th St. Ste 210
Lincoln, NE 68506
(402) 483-2572

Name: _____ Date of Exam: _____
Height: _____ ft _____ in Weight: _____ lbs Gender: Female Male
Smoker: Yes No Flu Vaccine: Yes No Pneumonia Vaccine: Yes No
Referring Physician: _____
Primary Care Physician: _____
Reason For Today's Consultation: _____

<p><u>Have you ever been diagnosed with:</u> Heart Disease: _____ Lung Disease: _____ Breast Disease: _____ Last Mammogram: _____ Intestinal Disease: _____ Neurologic Disease: _____ Diabetes: _____ Cancer: _____ Blood Transfusion: _____ Steroids: _____ Currently Pregnant: Yes / No Other Medical History: _____ _____ _____ _____</p>	<p><u>Family History Of:</u> Breast Cancer: Bleeding Disorder: Issues w/Anesthesia? Yes / No Other: <u>Medications:</u> (or attach med list) _____ _____ _____ _____ _____ _____ Medication Allergies: _____ _____ _____ Allergy to Latex? Yes / No</p>
--	--

Operations, Dates and Complications:

