Adams Plastic Surgery
Jason Adams, DO
San Juan Plastic Surgery
Todd Williams, MD

PATIENT PERSONAL HISTORY
*Confidential Document

Date: MRN:

Last Name	First Name	Sex M / F	Date of Birth / /	Age	Social Security #
Address		City	State, Zip		Marital Status Single / Married
Home Phone Cell Phone		e-mail			
Insurance Company	Employer/Job Title		Business Phone		
Referring Doctor / Primary Care Doctor	Emergency Contact / Power of Attorney		Emergency Contact Phone #		

Have you or any of your blood relatives been diagnosed with any of the following:

	You	Family	Nobody		You	Family	Nobody		You	Family	Nobody
Headaches	□	□	□	Heart attack	□	□	□	Blocked Leg Arteries	□	□	□
Thyroid Problems	□	□	□	Angina	□	□	□	Stomach Ulcer	□	□	□
Asthma	□	□	□	High Blood Pressure	□	□	□	Hepatitis	□	□	□
Emphysema	□	□	□	Stroke or TIA	□	□	□	Cirrhosis	□	□	□
COPD	□	□	□	Blood Clots	□	□	□	Skin Cancer	□	□	□
Diabetes	□	□	□	Abnormal Bleeding	□	□	□	HIV or AIDS/ARC	□		
Breast Cancer	□	□	□	Tuberculosis	□	□	□	Problems with Anesthesia	□	□	□

Do You Smoke? Y N How Much?_____

Do You Drink Alcohol? Y N How Much?_____

Do You Drink Caffeine? Y N How Much?_____

Have you been diagnosed with Sleep Apnea? Y N Do you use a CPAP? Y / N

Height:_____ Weight:_____

Are you currently experiencing any of the following symptoms?

Weight Loss	Y	N	Nausea/Vomiting	Y	N
Fever	Y	N	Joint Pain	Y	N
Blurry Vision	Y	N	Non healing skin sores	Y	N
Loss of Hearing	Y	N	Weakness in legs or arms	Y	N
Sore Throat	Y	N	Depression	Y	N
Chest Pain	Y	N	Enlarged lymph nodes	Y	N
Difficulty Breathing	Y	N	Seasonal allergies	Y	N

Are you left or right handed (which hand do you sign your name with)? Left Right Ambidextrous

Is your condition the result of an injury either at: Work Home Auto Accident N/A

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Name:_____

Allergies to medications and foods including the reaction or write "none" or "N/A":
Medication/Food **Reaction (itching, hives, can't breath, etc)**

List all medications including the dose and frequency (or provide a separate sheet if you have one):
Medication **Dose/frequency**

List all medical conditions you have been diagnosed with:

List all previous surgeries with approximate date:

Signature:_____ **Date:**_____