St. Jude Heritage Medical Group

Welcome to the Department of Plastic and Reconstructive Surgery.
Please fill out the following form. *All information is protected and confidential.*
Thank you!

Name:_____

How did you hear about Dr. McConnell? _____

(*Be specific, as we would like to thank them!)*

Date:_____ Age:_____

Reason for today's visit: (please be as specific as possible)

_____
_____
_____

MEDICAL INFORMATION:

Our goal is to help you. Please answer as truthfully and completely and possible.

Do you have any allergies to food or medication? Yes No

Allergy: What Happens:

_____
_____
_____

Do you take any anti-depressant medication? Yes No
List: Prescribed by:

_____

Pleaes list all medications, vitamins, herbal supplements that you are taking:

_____ _____
_____ _____
_____ _____
_____ _____

Date of last Physical Exam:_____

E-Mail Address:_____

May we contact you via e-mail? Yes No

Do you have or have a history of:

Heart Disease	___Yes ___No	Bulimia or Anorexia	___Yes ___No
Autoimmune Disorder	___Yes ___No	Chronic Illness	___Yes ___No
Asthma	___Yes ___No	Mental Illness	___Yes ___No
Drug Dependency	___Yes ___No	Blood Clotting Disorders	___Yes ___No
Anemia	___Yes ___No	Depression	___Yes ___No
Lung Disease	___Yes ___No	High Blood Pressure	___Yes ___No
Blood Disorders	___Yes ___No	Cancer	___Yes ___No
Serious Accident	___Yes ___No	Diabetes	___Yes ___No
Birth Control Usage	___Yes ___No	Sleep Apnea	___Yes ___No
If yes, Type:_____		CPAP Machine	___Yes ___No
Latex Allergy:	___Yes ___No	Environmental Allergy	___Yes ___No
Other:_____			

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

_____

_____

_____

List all previous Surgeries:

Type:_____	Date:_____	Performed by:_____
Type:_____	Date:_____	Performed by:_____
Type:_____	Date:_____	Performed by:_____
Type:_____	Date:_____	Performed by:_____
Type:_____	Date:_____	Performed by:_____

Have you had any cosmetic plastic surgery procedures? Yes No

Were you pleased with the outcome? Yes No

Do you have a family history of:

Skin Cancer	___Yes___No	Diabetes	___Yes___No
Cancer	___Yes___No	Arthritis	___Yes___No
Heart Disease	___Yes___No	Headache	___Yes___No
Congestive Heart Failure	___Yes___No	Stroke	___Yes___No
Hypertension	___Yes___No	Alcoholism	___Yes___No
Kidney Disease	___Yes___No	Mental Illness	___Yes___No
Asthma	___Yes___No	Coronary Artery Disease	___Yes___No
Emphysema	___Yes___No	Uterine Cancer	___Yes___No
Crohn's Disease	___Yes___No	Ovarian Cancer	___Yes___No
Hepatic Disorders	___Yes___No	Breast Cancer	___Yes___No
Hyperlipidemia	___Yes___No	Colon Cancer	___Yes___No

Thyroid Disorder	___Yes___No	Tendency for easing bruising	___Yes___No
Osteoporosis	___Yes___No	Skin wounds slow to heal	___Yes___No

CHILDBIRTH:

Number of Pregnancies? _____ Amount of weight gain with each pregnancy? _____

Number of children? _____ Age(s) of children? _____

Did you breastfeed? Yes / No

LIFESTYLE:

Single / Married / Divorced / Widowed / Other

Do you smoke? Yes / No Packs per day? _____

Number of Years _____

If you quit, when? _____

How many drinks containing alcohol do you drink per week? _____

Do you take Aspirin or Ibuprofen on a regular basis? Yes / No

Are you on a diet pill or diet program now? Yes / No

Do you take vitamins regularly? Yes / No

Height:_____ Weight:_____

Do you exercise? Yes / No Activity:_____

How Often? _____